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THE FUTURE OF MEDICARE

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BEFORE THE

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UNITED STATES SENATE
NINETY-EIGHTH CONGRESS
FIRST SESSION

WASHINGTON, D.C.

APRIL 13, 1983

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CONTENTS

Page

Opening statement by Senator John Heinz, chairman 1

Statement by Senator Charles H. Percy 18

Statement by Senator Larry Pressler 47

CHRONOLOGICAL LIST OF WITNESSES

Rivlin, Dr. Alice M., Washington, D.C., Director, Congressional Budget Office; accompanied by Paul B. Ginsburg, Deputy Assistant Director, Human Resources and Community Development Division; and Marilyn Moon, analyst, Human Resources and Community Development Division 7

Davis, Dr. Carolyne K., Washington, D.C., Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services; accompanied by Dr. George Schieber, Director, Office of Policy Analysis; and Patrice Feinstein, Associate Administrator for Policy 26

Newhouse, Dr. Joseph P., Santa Monica, Calif., head, economics department, the Rand Corp 58

Wilensky, Dr. Gail R., Rockville, Md., senior research manager, National Center for Health Services Research 66

Davis, Dr. Karen, Baltimore, Md., chairman, department of health policy and management, School of Hygiene and Public Health, Johns Hopkins University 72

THE FUTURE OF MEDICARE

WEDNESDAY, APRIL 13, 1983

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-562, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Percy, Pressler, Melcher, and Burdick.

Staff present: John C. Rother, staff director and chief counsel; Ann Langley and Nancy Kingman, professional staff members; M. Isabelle Claxton, communications director; Robin L. Kropf, chief clerk; and Angela Thimis and Kim Heil, staff assistants.

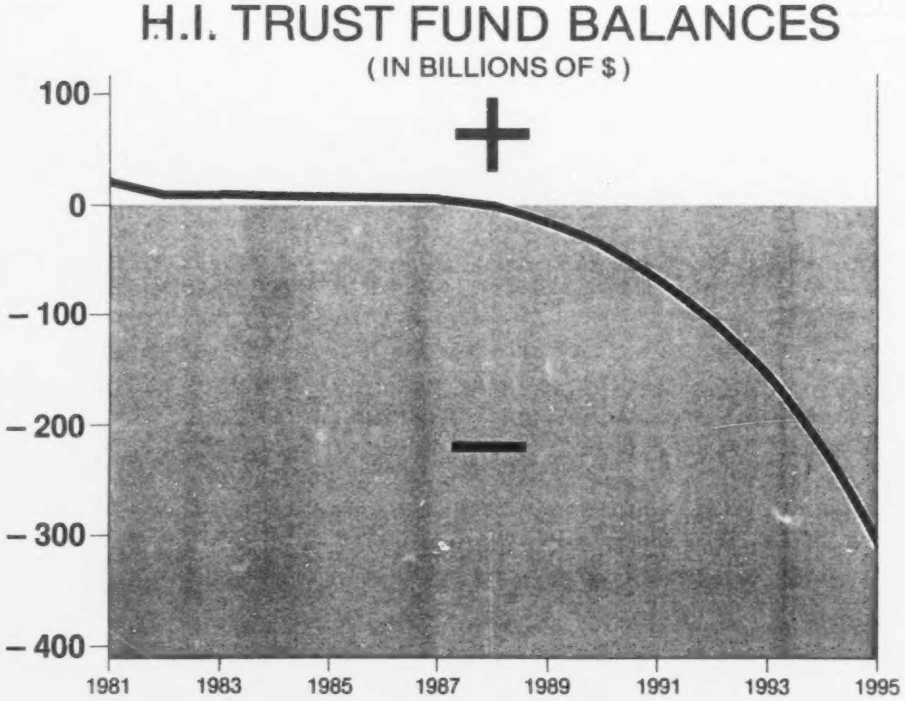
OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

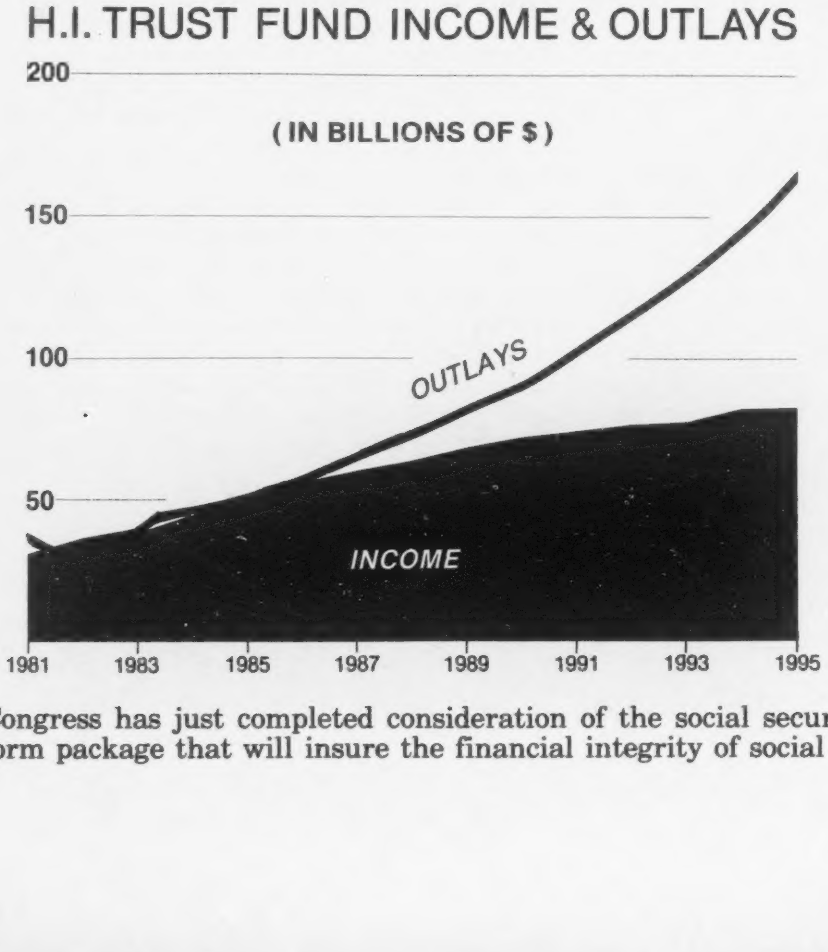
Chairman HEINZ. Good morning.

Today, we begin the first in a series of hearings by the Senate Special Committee on Aging on the future of medicare. This morning, we will focus on the long-term financial picture for the medical hospital insurance trust fund.

The fact is that medicare will face major financing problems in this decade. The speed at which the fund faces depletion and the magnitude of the deficits are indeed alarming.

Last August, the medicare hospital trust fund was projected to be sound until 1990 or 1991. Just a few months later, we have learned that the HI trust fund is expected to be depleted by 1998. The first chart shows the projected cumulative deficit of the HI trust fund will equal $300 billion by 1995, and as the second chart shows, this is largely the result of the cumulative discrepancy between the growth of revenues, of payroll taxes, and expenditures for hospital costs. Because the cumulative projected deficit is so large, maintaining the solvency of the health insurance trust fund will require major reforms in medicare and perhaps in our health care system as well.





Congress has just completed consideration of the social security reform package that will insure the financial integrity of social security. Next to social security, nothing is more important to the health and economic security of older Americans than the medicare program. But if we thought we had serious deficit problems with social security, a crisis of even greater magnitude looms for the future financing of medicare.

The deficit projected for medicare over the next 75 years is nearly three times the deficit that existed in social security before the passage of the social security package. Several months ago, I asked Dr. Alice Rivlin, the Director of the Congressional Budget Office, for an analysis of projections for the HI trust and options sufficient to meet future deficits. The CBO paper, released officially by the committee today, shows that medical care costs, particularly hospital costs, are growing faster than the taxes on payroll which support it. An important part of any longrun solution must include measures to control the rapid inflation of medical costs. If medical costs are not controlled, a difficult choice between substantial retrenchments in the medicare benefits and large tax increases will be necessary.

For that reason, we have asked the witnesses appearing today to discuss the potential options for maintaining medicare's solvency and the impact of these options on beneficiaries.

Our first witness is going to be Dr. Rivlin. Let me first note, however, that, having been a member of the National Commission on Social Security Reform, I saw that Commission come with great difficulty to the constructive, useful, and enactable conclusions that it did, and skate perilously close to the edge of failure. It seems to this Senator that because the medicare program, is so intimately bound to the factors influencing one of the largest segments of our economy—the health care industry—any attack on only the medicare program is likely to result in mere costshifting, when what we need most is significant reform of our overall health care system. I do not think that it is possible for anyone to overstate the difficulties that we face in grappling with this issue. Unfortunately, there is very little groundwork of a careful, thoughtful, and useful nature that will cost out the kinds of options that are available to us. One of the reasons that the Social Security Commission was able to make the kind of progress it did was because it was able not just to cost out the size of the short- and long-term problems, but it was also able to cost out with great specificity the options that were available to the Congress. At this point in medicare, we do not have the luxury of working with careful cost estimates of the options that may be necessary for reform.

So we have a very serious problem ahead of us, and it is for that reason that I am deeply indebted to the Congressional Budget Office for undertaking one of the first and most comprehensive analyses of medicare's financial future. It is not the last word, but it is a very important statement that will help focus our attention on this problem.

Senator John Glenn, the ranking minority member of this committee, and Senator William S. Cohen cannot be with us today because of prior commitments. They have, however, submitted statements for the record, and without objection they will be inserted at this point.

[The statements of Senators Glenn and Cohen follow:]

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, I am pleased that the Special Committee on Aging is holding this hearing to examine the solvency problem of the medicare hospital insurance trust fund, and the impact of potential solutions on the trust fund and on medicare beneficiaries.

During the past few years, congressional debate has intensified over how to restrain the growth in Federal health care spending. Of particular concern is medicare spending. Behind social security retirement, medicare is the second largest entitlement program in the Federal budget. The size and growth of medicare have made it a target in the budgetary debate, and the solvency of the medicare hospital insurance trust fund is also at issue.

For the past 3 years, Congress has taken steps to contain medicare spending. The 1981 Omnibus Budget Reconciliation Act reduced medicare spending by $1.4 billion in fiscal 1982. Last year, medicare provisions were incorporated into the Tax Equity and Fiscal Responsibility Act (TEFRA) to produce an estimated savings of $2.7 billion in fiscal 1983 and a savings of $12 billion over the 3-year period from fiscal 1983 through 1985. This year as part of the Social Security Act Amendments of 1983, Congress passed medicare prospective payment legislation that will fundamentally alter the way in which the Government reimburses hospitals for medicare services.

Since the program's inception, medicare has paid hospitals on the basis of incurred costs. Many health care analysts have attributed the widespread practice of incurred-cost reimbursement, automatically paid by public and private health insurance programs, as an important factor in hospital cost inflation. Under the prospective legislation, future medicare payments will be set in advance and not based on an individual hospital's costs, adding risk for hospitals with higher-than-average costs. Unlike the present system, hospitals effectively containing their costs could be rewarded because their medicare payments will not go down as a result.

While I am hopeful that the Social Security Act Amendments of 1983 will adequately meet the present and future financing needs of social security's cash-benefit retirement and disability programs, the legislation is only one step in addressing the solvency needs of the medicare program. The National Commission on Social Security Reform's solvency plan deliberately dealt only with the financing needs of social security's cash-benefit programs, because Commission members said that medicare's problems were problems of the health care system in general and should only be considered within the broad context of health care cost-containment. Congress then developed and added the medicare prospective legislation to the social security plan.

Even with recent congressional action, medicare remains the fastest growing part of this Nation's social security system. Unlike cash benefits, which bear a direct relationship to an individual's social security contributions, the level of medicare benefits provided depends largely upon how sick one becomes and what kind of medical care is needed. Consequently, medicare benefits may far exceed contributions into the system. Unlike cash benefits, medicare payments do not go directly to beneficiaries but instead to the providers of their medical services.

Medicare serves as the major source of health insurance for acute medical services for elderly and disabled citizens receiving social security. While less than half of the health care expenditures of the elderly are reimbursed through medicare, the program pays for 74 percent of all hospital costs for Americans over the age of 65.

Nearly 29 million people are covered by the medicare hospital insurance program, nearly 90 percent are 65 and older. This portion of our population is not typical in its health care needs, resources, or concerns. On average, people over the age of 65 use hospitals at 2.8 times the rate of those under 65, and their hospital length of stay is 1.75 times as long. Breaking down these figures, according to data from the Health Care Financing Administration, 9 percent of elderly medicare beneficiaries accounted for more than 70 percent of the medicare dollars spent in 1979. For many of these people, medicare was paying for health services provided during the last year of their life. An estimated 77 percent of older beneficiaries use medicare services at a rate that requires program payments of less than $500 yearly. While medicare provides insurance coverage for many citizens, relatively few of the program's beneficiaries use the bulk of its resources.

Since medicare's enactment in 1965, life expectancy has increased dramatically in upper age groups, as have hospitalization rates and certain types of surgical procedures. For some, the quality of life beyond age 65 has also greatly improved. The doubling of cataract operations is one example of enhancing life for many older persons.

In terms of Government expenditures, medicare now accounts for more than 60 percent of the Federal health care budget. In fiscal 1982, medicare spending alone accounted for about 7 percent of Federal budget outlays. Medicare expenditures increased more than 20 percent in 1980 and 1981. Last year, due to savings enacted the year before and a decline in the growth of health care costs in general, medicare spending grew by about 16 percent. This still represents a rate of increase more than 2½ times the inflation rate and 3½ percent more than the rate of increase in medical care expenditures for all ages.

Medicare is the largest health care financing program in this country and the single largest purchaser of medical services in the world. The need to pursue cost-containment objectives with a program of this size is obvious. However, we must exercise caution against concentrating all our national health care cost-containment goals on medicare alone. We must take steps to improve the medicare program, but cannot restructure our health care system through this program alone.

Rising medical costs are a national problem. Last year this country spent more than $320 billion on medical services. Medical expenditures are consuming an ever-growing percentage of our gross national product (GNP). In 1982, health care spending grew at more than twice the rate of inflation, and represented 10.4 percent of the GNP, an increase of 0.6 percent from the year before.

Spending for hospital care is the largest component of national health care spending, accounting for 47 percent of the Nation's medical bill. In 1982, expenditures for hospital care increased 16 percent above the previous year, and hospital costs rose three times the general rate of inflation.

Due to health care inflation, the cost of private health insurance coverage has been rising rapidly in recent years. As employers pay increasingly higher medical insurance premiums, these increased costs are manifested in higher prices and, perhaps, in greater unemployment. Unchecked medical cost inflation which causes higher prices can mean a weakening of America's competitive position in the world.

A true effort to address the basic issues of health care cost-containment in an equitable fashion will require an agenda defined to include more than the medicare program. We will need to determine the proper resources to address and meet the health care concerns of our Nation's young, middle-aged, and older persons. Carefully designed, but not necessarily greatly increased, cost-sharing may be able to play a constructive role in addressing the medical inflation issue. Methods of paying for both physician and hospital care that do encourage efficiency and do not encourage price increases will also be part of the solution.

Simply requiring larger out-of-pocket payments from medicare beneficiaries is not a promising solution to the financing problems of the medicare program, and by itself, it is not an appropriate response to those problems. In fact, while increasing out-of-pocket expenditures alone may buy temporary solvency time for the medicare hospital insurance program, this bought time may act to deflect attention and effort away from difficult, yet more hopeful, solutions.

In exploring solutions to health care cost-inflation, we must also remember that the elderly and disabled Americans served by the medicare program represent an unusually vulnerable group of citizens. A large majority live on fixed incomes and a disproportionate number suffer from chronic illnesses. With the bulk of medicare's funding now going for rapidly rising hospital costs, little serious attempt has been given to closing gaps in medicare coverage which still remain, such as outpatient drugs, basic dental services, and long-term care. These gaps remain a burden and source of real concern for many other Americans. The financial impact of medical services not reimbursed under medicare is also considerable. Health care costs for the elderly not paid by medicare equal almost the same share of income that health care costs consumed for older Americans before enactment of the medicare program.

As the ranking minority member of the Senate Special Committee on Aging, I look forward to reviewing today's testimony from our recognized panel of health care experts on the related subjects of medicare financing and health care cost-containment. Hopefully, with your help, we can begin constructive debate regarding the health care financing issues which face our country.

STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, I commend you for scheduling today's hearing on the serious funding shortfall facing the medicare program. Adequate and affordable health care is vital to all Americans, and particularly so in the case of our senior population.

The rising cost of medical care is particularly frightening to older Americans, many of whom live on limited or fixed incomes and find it difficult to make ends meet. For these individuals, expenditures for health care comprise a significant portion of their monthly income. I recently heard from one of my constituents, an 80-year-old widow, who wrote, "It seems like every time I have a prescription refilled they've increased the prices." Of the $333.75 per month she receives from social security, $111.32 goes for prescription medicine and health insurance costs. When fully a third of one's monthly pay check is eaten up by such costs, which shows no sign of abating, it is no wonder we hear a clamoring for something to be done.

With increasing out-of-pocket expenditures for medicine and routine medical services, the existence of a health care program like medicare becomes absolutely vital to the elderly for their acute care needs. Statistics tell us that health care costs are disproportionately higher for those over 65 years of age, in some cases 2½ times the cost of care for younger individuals. Complicating the situation is the fact that approximately 80 percent of the elderly suffer from at least one chronic medical condition.

Medicare serves as the major source of insurance for acute medical care services for the elderly and, since July 1973, for disabled persons receiving social security. In fiscal year 1982, nearly 29 million persons were enrolled in medicare hospital insurance, 90 percent of whom were 65 or older.

Because the medicare program focuses on the acute care needs of the elderly, it has become an indispensable program for this segment of our population. In 1978, medicare paid for 69 percent of hospital and physician expenses for the elderly. Today, that figure is even higher. The program's financial difficulties, which the committee gathers today to discuss, thus affect the expanding elderly population of this country, and we must study the available options very carefully to insure that a resolution of this significant problem does not have an undue impact on those who need extensive health care the most.

The looming medicare deficit, estimated to grow to $300 to $400 billion by 1995, coupled with the rate at which the program's costs are expanding—an average annual rate of 17.7 percent—present a formidable challenge to Congress. The same sense of urgency and commitment that characterized our recent efforts to reform the social security system must be repeated in the case of the medicare program, which now constitutes one of the largest and most rapidly expanding areas of the Federal budget. In fiscal year 1982, it comprised 7 percent of budget outlays, a huge percentage for a single program.

Clearly, the average elderly citizen is deeply concerned with skyrocketing hospital costs and with suggestions that they pay more out-of-pocket for their acute care needs. But the fact remains that some significant changes will have to be made if the system is to remain solvent.

The staff of the Aging Committee has put together an objective, frank, and thorough report on the options available to Congress in resolving this issue. While it paints a pessimistic picture, it does provide us with an excellent basis on which to begin meaningful discussions.

In addition, the Congressional Budget Office has issued a report entitled "Changing the Structure of Medicare Benefits: Issues and Options" which provides Congress with sufficient facts and figures that demonstrate the immediate need to take action.

The medicare financing issue is a complex and emotional issue. But its impacts are very real and human to the millions of Americans who depend on medicare benefits for their health care needs. I trust that this hearing and others that follow will help us identify the various paths we might take in correcting the current situation.

Again, I commend the chairman and the staff for their work on this issue.

Chairman Heinz. Dr. Rivlin, we welcome you. I just want to again thank you and your staff for the excellent report you have given to us. It is statistically very, very solid, and it is the kind of effort we are going to need as we move to try and tackle this problem.

Dr. Rivlin.

STATEMENT OF DR. ALICE M. RIVLIN, WASHINGTON, D.C., DIRECTOR, CONGRESSIONAL BUDGET OFFICE; ACCOMPANIED BY PAUL B. GINSBURG, DEPUTY ASSISTANT DIRECTOR, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION; AND MARILYN MOON, ANALYST, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION

Dr. RIVLIN. Thank you very much, Mr. Chairman.

I am delighted to be here as you tackle this very difficult problem. I would agree with your analysis that it is perhaps the most difficult problem that the Congress will face in the upcoming years, considerably harder for a lot of reasons than the social security problem, as you noted.

Total medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of rapidly rising medical care costs, and CBO projections suggest continued high growth. This projected growth in outlays threatens the solvency of the hospital insurance trust fund, which is financed almost exclusively by payroll taxes.

As indicated in the Congressional Budget Office report prepared for this committee, without changes in current law, the HI trust fund would be depleted by 1988 and, by the end of 1995, would have a cumulative deficit of about $300 billion, figure 1 in my prepared statement shows.[1]

The urgency of the HI financing problem has overshadowed the equally serious problems in the other part of medicare—supplementary medical insurance or SMI. Although SMI does not face insolvency in its trust fund, because transfers from general revenues are required by law, its increased outlays, which account for about one-third of total medicare expenditures, are adding significantly to the Federal deficit.

My testimony this morning will discuss, first, the factors that contribute to the growth in medicare outlays and the scope of the problem facing both portions of medicare in the next few years, and second, the tradeoffs among general options for dealing with this problem.

Medicare serves as the principal insurer of acute health care expenditures for 29 million elderly and disabled persons. It reimburses hospitals and most other providers directly for the costs of covered services used by enrollees, with HI paying for short-stay hospital inpatient care and SMI covering physician visits, outpatient services, and other miscellaneous medical care. In fiscal year 1982, medicare outlays totaled $50 billion, of which $35 billion was for HI.

In HI, most of the projected growth in outlays stems from higher expenditures per person rather than growth in the number of beneficiaries. For example, over the period 1982 to 1995, hospital costs attributable to medicare beneficiaries are projected to grow at an average annual rate of 13.2 percent, of which growth in the number of beneficiaries and their increasing age explain only 2.2 percentage points. Slightly over half of the higher per capita expenditures is expected to come from rising prices that hospitals pay for labor and other inputs. The remainder is due to increased services provided per patient and higher rates of admissions to hospitals.

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[1] See page 13.

The projected HI deficit results from the fact that the earnings that are taxed to provide the fund's revenues are projected to grow much more slowly than hospital costs—7 percent per year as compared to 13.2 percent. As a consequence, despite the significant program cuts enacted in 1981 and 1982, balances in the HI trust fund will start declining in 1984 and be depleted within 4 years.

Like HI, outlays under SMI are also projected to increase rapidly, by almost 16 percent per year through 1988. This growth is expected to result from increases in the amount paid for each service, more services delivered per beneficiary, and changes in the mix of services toward more costly procedures.

Financing for SMI, in contrast to HI, is based on premiums paid by enrollees and on appropriations from general revenues. The monthly premiums, now $12.20, are currently set so as to insure that beneficiaries pay approximately one-quarter of the costs of SMI. After 1985, however, the premium increase will again be limited to the increase in the Consumer Price Index. Between 1972 and 1982, this type of limitation led to a decline in the share of SMI outlays covered by premiums from the originally legislated 50 percent to the current share of 25 percent.

Since by law appropriations from general revenues to SMI must be sufficient to guarantee solvency of the trust fund, SMI does not face a financing crisis per se. Rather, concern arises over this part of medicare because the projected growth of SMI is so much higher than the growth of general revenues—that is, Federal tax revenues not earmarked for specific purposes.

Under current projections, general revenue contributions would have to rise about 17 percent per year to finance the growth in SMI. Figure 2 in my prepared statement illustrates the projected growth in SMI outlays and premiums. Such growth would increase the share of those revenues from 3.7 to 5.7 percent of the Federal tax revenues not earmarked for other uses. If general revenue contributions to SMI were restricted to a rate of growth that would leave their share of general revenues unchanged, outlays would have to be reduced by almost $27 billion over the 1984 through 1988 period.

As to options, medicare's financing problems reflect the increasing medical care costs occurring throughout the health care system. In 1982, 10 percent of the gross national product was devoted to medical care, up from only 6 percent in 1965. Since medicare finances services purchased from the private sector without any restriction on the beneficiary's choice of provider, systemwide changes in the delivery of medical care may be necessary to slow the growth of medicare outlays.

Since most broad reforms that would control system costs are not likely to have a major impact on medicare outlays in the short run, however, it will also be necessary to make program changes that directly affect outlays or revenues. Moreover, the deficit in the HI trust fund is of such a magnitude that resolving it through any single change in medicare is unlikely to be politically acceptable. Some combination of available options will likely be required, affecting three basic groups—that is, providers, beneficiaries, and taxpayers.

One major strategy for reducing the growth in medicare outlays would be to limit the amounts that medicare pays to providers—that is, hospitals and physicians. To the extent that costs of providing services would be shifted to other payers, however, this approach would pass the effects of the cuts onto other users of health care.

Changes in hospital reimbursement. In the last year, the Congress has enacted major revisions in medicare hospital reimbursement. The Tax Equity and Fiscal Responsibility Act of 1982 reduced reimbursements substantially and initiated a transition toward a prospective reimbursement system. The 1983 Social Security Amendments speeded the move to prospective reimbursement and chose diagnostic-related groups, or DRG's, as the basis of payment. Prospective reimbursement carries strong incentives for hospitals to contain costs, since hospitals that provide less costly care can keep the difference between their reimbursements and actual costs, while less efficient hospitals do not recoup all their costs.

But the legislation left unresolved a major question—how tight the prospective rates are to be after 1985. This is to be decided by the Secretary of Health and Human Services, advised by an independent commission. By 1985, reimbursements are projected to be about 9 percent below the level they would have been if they had continued to be based on actual costs. The Secretary might choose to maintain this 9-percent gap or might continue to tighten the limits further—for example, by continuing the formula specified for 1984 and 1985.

While successive tightening of reimbursements could cut Federal outlays substantially if applied only to medicare reimbursements and not to those of other payers, it would run a substantial risk of reducing beneficiaries' access to quality care.

Changes in physician reimbursement. Currently, the level of reimbursement received by physicians under SMI is based on "reasonable" charges, which may not exceed the lowest of physicians' actual charges, their customary charges for that service, or the applicable prevailing charges in the locality. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to cut growth of physicians' reimbursements. By 1981, average reimbursable charges were 32 percent lower than actual submitted charges.

Mr. Chairman, are you eager to observe a time limit on the testimony.

Senator **Percy** [presiding]. I think I would leave it to your judgment as to whether you want to complete your statement. That is perfectly all right.

Dr. **Rivlin**. I would be happy to complete it, but——

Senator **Percy**. If you want to summarize it, the entire text of it will be incorporated in the record. Regretfully the chairman had to go to the floor for his amendment, and I have to go to the floor when he comes back to manage the Adelman nomination. So it will just depend on whether you want to complete the statement in full or go to questions.

Dr. **Rivlin**. Well, let me finish reading it. It will take about 5 more minutes to finish it, and I think that will be the most useful.

Senator **Percy**. Fine.

Senator **Burdick**. I will be here to listen.

Senator **Percy**. Good, good.

I will be here for 45 minutes, so we have time.

Dr. **Rivlin**. Fine.

One way to cut Federal costs further would be to apply more stringent limits to the growth of "reasonable" charges. For example, the administration has proposed freezing all physicians' reimbursement rates for 1 year.

Alternatively, there could be more basic changes in the structure of reimbursements for particular services or types of physicians. For example, the growth in fees for surgery could be limited for several years. Many contend that our medical care system overemphasizes surgery and other acute procedures relative to primary care. Changing relative reimbursements could influence this mix of medical services.

As long as physicians are not required to accept assignment, however—that is, as long as they are permitted to charge patients in excess of "reasonable" charges—budget savings resulting from reduced reimbursements might be achieved mostly at the expense of higher costs for beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment. Physicians could be required to accept assignments or be encouraged to do so by paying higher reimbursements to those who do. While these options could limit the additional charges that would be passed on to beneficiaries, they could also result in some physicians refusing to participate in medicare, thereby limiting beneficiaries' access to care.

Beneficiaries are now required, under both portions of medicare, to share some of the costs of covered services. Hospitalized beneficiaries must pay a deductible amount in each benefit period, but are not liable for additional cost sharing until they have been confined for more than 60 days. Under SMI, the most important cost sharing is the 20 percent of each covered service that must be paid by the beneficiary once a relatively small deductible has been met.

Beneficiaries could pay a greater share of the costs of medicare-covered services through higher premiums, deductible amounts, or coinsurance. Such changes could generate large amounts of Federal savings, although they would do so by substantially increasing out-of-pocket costs for the elderly and disabled. While beneficiaries have not been subject to major increases in cost-sharing to date, they already pay about one-fourth of the rapidly rising costs of medicare-covered services and even more for other health services not covered by medicare.

In general, choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. For example, increases in costs to beneficiaries across the board—such as through premiums—would affect large numbers of beneficiaries, but each by a small amount. HI currently has no premium, and if the goal is to spread the costs among beneficiaries, such a premium might be considered.

On the other hand, options that are tied to the use of medical care services, such as a required payment for each day of hospitalization, might result in somewhat lower use of health care services, but would concentrate the additional liability on the small portion of beneficiaries who already have the highest medical expenses. Such persons might be protected through catastrophic limits on the liability of any one beneficiary, but this would diminish substantially the Federal savings from cost-sharing.

The administration has proposed several changes that would directly affect beneficiaries, including an increase in the SMI premium and an expansion of hospital coinsurance, combined with a catastrophic cap on liability for hospital bills. The SMI premium would rise gradually over time to a maximum of 35 percent of the average SMI benefits, reducing general revenues required for SMI by $8.6 billion over the 1984 to 1988 period.

The coinsurance proposal would effectively shift the burden of costs from those who have very long hospital stays to those with shorter periods of hospitalization. The proposal's catastrophic protection would substantially decrease costs for less than 1 percent of medicare beneficiaries, while increasing coinsurance for the nearly one-fourth of medicare beneficiaries with hospital stays of fewer than 60 days. The net results of these effects would be 5-year budget savings of $8.4 billion.

A third approach to maintaining the solvency of the HI trust fund would be increased taxes—higher payroll taxes or transfers from general revenues. But any tax increase implies that current taxpayers would be supporting a level of benefits for medicare participants that already is well in excess of contributions made by such individuals. Further, if SMI outlays were not also reduced, increased individual and corporate income tax revenues would be required to help finance those benefits. On the other hand, this approach would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care.

The payroll tax contributions by employees and employers are now scheduled to rise from the current 1.3 percent of covered wages to 1.35 percent in 1985 and 1.45 percent in 1986. Combined with other scheduled increases in social security payroll taxes, this means that these rates will increase by 1.9 percentage points, or 31 percent, between 1975 and 1990. Further increases could cover the HI trust fund deficit but might have adverse effects on employment, since the cost to employers of hiring workers would rise. Moreover, social security payroll taxes are already accounting for an increasing share of total Federal revenues, rising from 26 percent in 1980 to 33 percent in 1988, and this approach would exacerbate this trend.

General revenues could be used to aid HI, as well as to maintain SMI at its projected levels. Medicare benefits, unlike social security retirement benefits, are not related to the amount of payroll contributions made by beneficiaries, and hence might be appropriately financed by taxes from all sources. This approach would not change the overall tax burden compared to increased payroll tax rates, however, it would merely redistribute it. Moreover, the projections of continued high Federal deficits imply that higher taxes of various sorts might be needed to replace revenues used to finance medicare.

In conclusion, Mr. Chairman, the projected growth in medicare poses problems for controlling the Federal deficit and for insuring the solvency of the HI trust fund, a problem whose magnitude, without changes in current law, will continue to expand for the foreseeable future.

There are various options, and they are all difficult. The CBO stands ready to help the committee as you think about them.

Senator PERCY. Dr. Rivlin, I thank you very much indeed.

[The prepared statement of Dr. Rivlin follows:]

PREPARED STATEMENT OF DR. ALICE M. RIVLIN

Total medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of rapidly rising medical care costs, and Congressional Budget Office (CBO) projections suggest continued high growth. This projected growth in outlays threatens the solvency of the hospital insurance (HI) trust fund, which is financed almost exclusively by payroll taxes. As indicated in a CBO report prepared for this committee, without changes in current law the HI trust fund would be depleted by 1988 and, by the end of 1995, would have a cumulative deficit of about $300 billion (see figure 1).[1]

The urgency of the HI financing problem has overshadowed the equally serious problems in the other part of medicare—supplementary medical insurance (SMI). Although SMI does not face insolvency in its trust fund, because transfers from general revenues are required by law, its increased outlays—which account for about one-third of total medicare expenditures—are adding significantly to the Federal deficit.

My testimony today will discuss: The factors that contribute to growth in medicare outlays and the scope of the problem facing both portions of medicare in the next few years; and the tradeoffs among general options for dealing with the problem.

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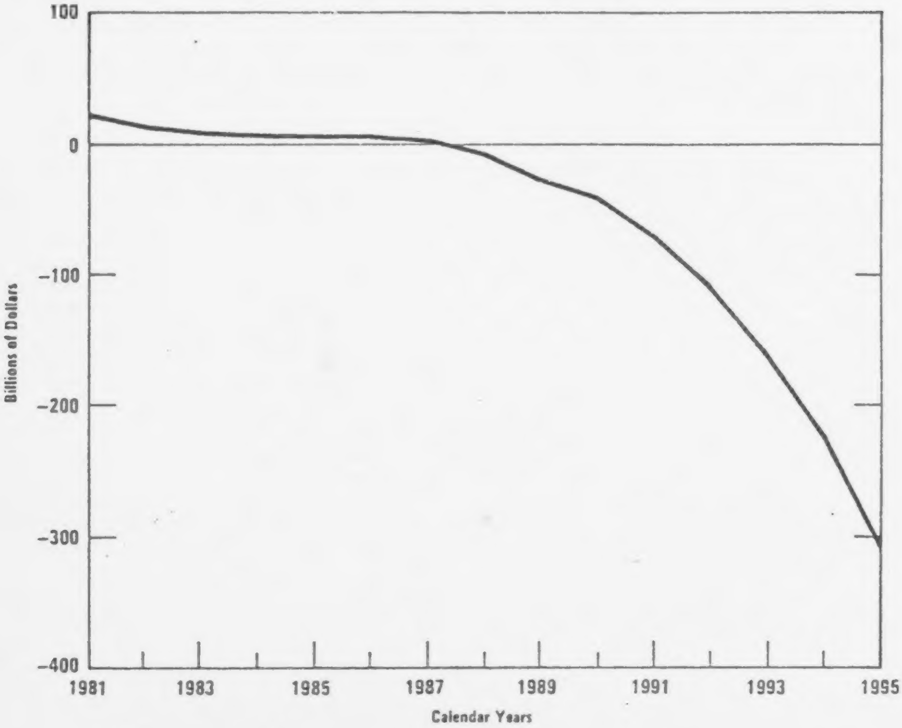
[1] The recent passage of the Social Security Amendments of 1983 has resolved some of the uncertainty about the projected size of the deficit, making the $300-billion estimate contained in the CBO report more relevant than the report's $400-billion estimate. For a discussion of the general HI financing problem, see Special Committee on Aging, U.S. Senate, committee print, "Prospects for Medicare's Hospital Insurance Trust Fund," 98-17 (March 1983).

Figure 1.

End-of-Year Balances in the Hospital Insurance Trust Fund



SOURCE: Preliminary CBO estimates.

NOTE: The figures presented here assume that the hospital reimbursement payment rates created under the Social Security Amendments of 1983 will be updated yearly so as to maintain the same level of stringency as would have occurred if the Tax Equity and Fiscal Responsibility Act of 1982 had been extended.

THE NATURE AND SCOPE OF THE PROBLEM

Medicare serves as the principal insurer of acute health care expenditures for 29 million elderly and disabled persons. It reimburses hospitals and most other providers directly for the costs of covered services used by enrollees—with HI paying for short-stay hospital inpatient care and SMI covering physician visits, outpatient services, and other miscellaneous medical care. In fiscal year 1982, medicare outlays totaled $50 billion, $35 billion of which was for HI.

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Hospital insurance

In HI, most of the projected growth in outlays stems from higher expenditures per person, rather than growth in the number of beneficiaries.[2] For example, over the 1982-85 period, hospital costs attributable to medicare beneficiaries are projected to grow at an average annual rate of 13.2 percent, of which growth in the number of beneficiaries and their increasing age explain only 2.2 percentage points. Slightly over half of the higher per capita expenditures is expected to come from rising prices that hospitals pay for labor and other inputs. The remainder is due to increased services provided per patient and higher rates of admissions to hospitals.

The projected HI deficit results from the fact that the earnings that are taxed to provide the fund's revenues are projected to grow much more slowly than hospital costs—7 percent per year compared to 13.2 percent. As a consequence, despite the significant program cuts enacted in 1981 and 1982, balances in the HI trust fund will start declining in 1984 and be depleted within 4 years.

Supplementary medical insurance

Like HI, outlays under SMI are also projected to increase rapidly, by almost 16 percent per year through 1988. This growth is expected to result from increases in the amount paid for each service, more services delivered per beneficiary, and changes in the mix of services toward more costly procedures.

Financing for SMI—in contrast to HI—is based on premiums paid by enrollees and on appropriations from general revenues. The monthly premiums (now at $12.20) are currently set so as to insure that beneficiaries pay approximately 25 percent of the costs of SMI. After 1985, however, the premium increases will again be limited to the increase in the Consumer Price Index. Between 1972 and 1982, this limitation led to a decline in the share of SMI outlays covered by premiums from the originally legislated 50 percent to the current share of 25 percent. Since, by law, appropriations from general revenues to SMI must be sufficient to guarantee solvency of the trust fund, SMI does not face a financing crisis per se. Rather, concern arises over this part of medicare because the projected growth of SMI is so much higher than the growth of general revenues—that is, Federal tax revenues not earmarked for specific purposes.[3]

Under current projections, general revenue contributions would have to rise about 17 percent per year to finance the growth in SMI (figure 2 illustrates the projected growth in SMI outlays and premiums).[4] Such growth would increase the share of these revenues from 3.7 to 5.7 percent of Federal tax revenues not earmarked for other uses. If general revenue contributions to SMI were restricted to a rate of growth that would leave their share of general revenues unchanged, outlays would have to be reduced by almost $27 billion over the 1984 to 1988 period.

OPTIONS FOR MEDICARE

Medicare's financing problems reflect the increasing medical care costs occurring throughout the health care system. In 1982, 10 percent of the gross national product was devoted to medical care, up from only 6 percent in 1965. Since medicare finances services purchased from the private sector without any restriction on the beneficiary's choice of provider, systemwide changes in the delivery of medical care may be necessary to slow the growth of medicare outlays.

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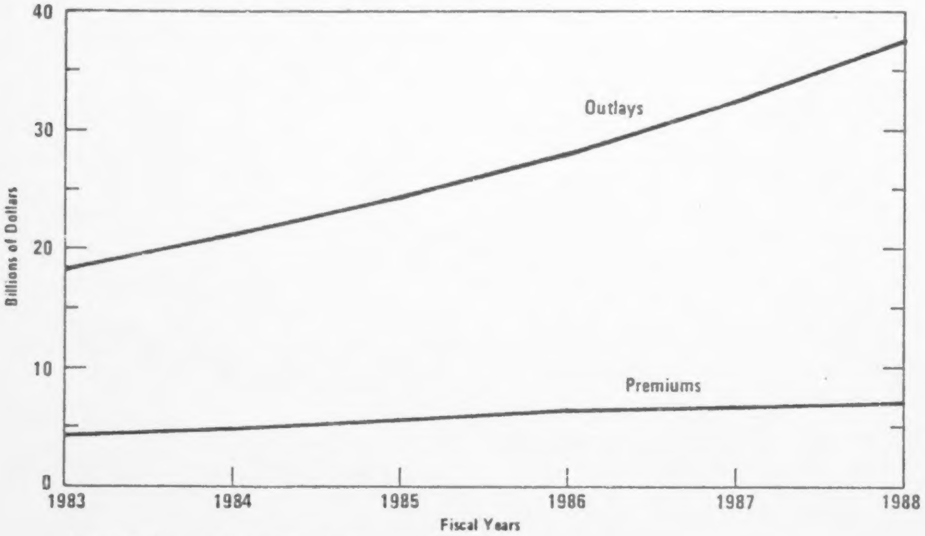
[2] The term "beneficiaries" is used here to refer to all those enrolled in medicare and not just those actually receiving covered services.

[3] This primarily includes personal and corporate income taxes and excludes payroll taxes used to support social security and unemployment insurance, for example.

[4] The 17-percent figure is higher than the projected increase in outlays of 16 percent because SMI premiums are scheduled to grow at a slower rate after 1985 when, under current law, they will again be limited by the growth in the social security cost-of-living increase. For the 3-year period 1983-85, premiums will be set to fund 25 percent of incurred costs.

Figure 2.
Projected Growth in SMI Outlays and Premiums



SOURCE: Congressional Budget Office.

Since most broad reforms that would control system costs are not likely to have a major impact on medicare outlays in the short run, it will also be necessary to make program changes that directly affect outlays or revenues. Moreover, the deficit in the HI trust fund is of such a magnitude that resolving it through any single change in medicare is unlikely to be politically acceptable. Some combination of available options will likely be required, affecting three basic groups—providers, beneficiaries, and taxpayers.[5]

Reductions in reimbursement to providers

One major strategy for reducing the growth of medicare outlays would limit the amounts that medicare pays providers—that is, hospitals and physicians. To the extent that costs of providing services would be shifted to other payers, however, this approach would pass the effects of the cuts onto other users of health care.

Changes in hospital reimbursement.—In the last year, the Congress has enacted major revisions in medicare hospital reimbursement. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) reduced reimbursements substantially and initiated a transition toward a prospective reimbursement system. The 1983 Social Security Amendments speeded the move to prospective reimbursement and chose diagnostic related groups (DRG's) as the basis of payment. Prospective reimbursement carries strong incentives for hospitals to contain costs, since hospitals that provide less costly care can keep the difference between their reimbursements and actual costs, while less efficient hospitals do not recoup all their costs.

But the legislation left unresolved a major question—how tight the prospective rates are to be after 1985. This is to be decided by the Secretary of Health and Human Services, advised by an independent commission. By 1985, reimbursements are projected to be about 9 percent below the level they would have been if they had continued to be based on actual costs. The Secretary might choose to maintain this 9-percent gap, or might continue to tighten the limits further, for example, by continuing the formula specified for 1984 and 1985 [6] While successive tightening of reimbursements would cut Federal outlays substantially, if applied only to medicare reimbursements and not to those of other payers, it would run a substantial risk of reducing beneficiaries' access to quality care.

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[5] The impacts on the Federal budget of various illustrative options are shown in the appendix.

Changes in physician reimbursement.—Currently, the level of reimbursement received by physicians under SMI is based on "reasonable" charges, which may not exceed the lowest of physicians' actual charges, their customary charges for that service, or the applicable prevailing charges in the locality. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to cut growth of physicians' reimbursements. By 1981, average reimburseable charges were 32 percent lower than actual submitted charges.

One way to cut Federal costs further would be to apply more stringent limits to the growth of "reasonable" charges. For example, the administration has proposed freezing all physicians' reimbursement rates for 1 year.

Alternatively, there could be more basic changes in the structure of reimbursements for particular services or types of physicians. For example, the growth in fees for surgery could be limited for several years. Many contend that our medical care system overemphasizes surgery and other acute procedures relative to primary care. Changing relative reimbursements could influence this mix of medical services.

As long as physicians are not required to accept assignment, however—that is, as long as they are permitted to charge patients in excess of "reasonable" charges—budget savings from reduced reimbursements might be achieved mostly at the expense of higher costs for beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment. Physicians could be required to accept assignment or encouraged to do so by paying higher reimbursements to those who do. While these options could limit the additional charges that would be passed on to beneficiaries, they could also result in some physicians refusing to participate in medicare, thereby limiting beneficiaries' access to care.

Changes in the benefit structure

Beneficiaries are now required—under both portions of medicare—to share some of the costs of covered services. Hospitalized beneficiaries must pay a deductible amount in each benefit period, but are not liable for additional cost-sharing until they have been confined more than 60 days. Under SMI, the most important cost-sharing is the 20 percent of each covered service that must be paid by the beneficiary once a relatively small deductible has been met.

Beneficiaries could pay a greater share of the costs of medicare-covered services, however—through higher premiums, deductible amounts, or coinsurance,[7] for example. Such changes could generate large amounts of Federal savings, although they would do so by substantially increasing out-of-pocket costs for the elderly and disabled.[8] While beneficiaries have not been subject to major increases in cost-sharing to date, they already pay about one-fourth of the rapidly rising costs of medicare-covered services, and even more for other health services not covered by medicare.

In general, choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. For example, increases in costs to beneficiaries across-the-board—such as through premiums—would affect large numbers of beneficiaries, but each by a small amount. HI currently has no premium, and if the goal is to spread the costs among beneficiaries, such a premium might be considered.

On the other hand, options that are tied to the use of medical care services—such as a required payment for each day of hospitalization—might result in somewhat lower use of health-care services, but would concentrate the additional liability on the small portion of beneficiaries who already have the highest medical expenses. Such persons might be protected through catastrophic limits on the liability of any one beneficiary, but this would diminish substantially the Federal savings from cost-sharing.

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[6] This formula of "market basket plus one" allows reimbursements to increase at the rate of growth of increases in hospital input prices plus 1 percent.

[7] Coinsurance refers to a beneficiary's liability for a percentage of the costs of each unit of medical care.

[8] A wide range of such options is discussed in "Changing the Structure of Medicare Benefits: Issues and Options," Congressional Budget Office (March 1983).

The administration has proposed several changes that would directly affect beneficiaries, including an increase in the SMI premium and an expansion of hospital coinsurance combined with a catastrophic cap on liability for hospital bills. The SMI premium would rise gradually over time to a maximum of 35 percent of average SMI benefits, reducing general revenues required for SMI by $8.6 billion over the 1984-88 period.

The coinsurance proposal would effectively shift the burden of costs from those who have very long hospital stays to those with shorter periods of hospitalization. The proposal's catastrophic protection would substantially decrease costs for less than 1 percent of medicare beneficiaries, while increasing coinsurance to the nearly one-fourth of medicare beneficiaries with hospital stays of less than 60 days. The net result of these effects would be 5-year budget savings of $8.4 billion.

Higher taxes

A third approach to maintain the solvency of the HI trust fund would be increased taxes—higher payroll taxes or transfers from general revenues. But any tax increase implies that current taxpayers would be supporting a level of benefits for medicare participants that already is well in excess of contributions made by such individuals. Further, if SMI outlays were not also reduced, increased individual and corporate income tax revenues would be required to help finance those benefits. On the other hand, this approach would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care.

The payroll tax.—Payroll tax contributions by employees and employers are now scheduled to rise from the current 1.30 percent of covered wages to 1.35 percent in 1985 and 1.45 percent in 1986. Combined with other scheduled increases in social security payroll taxes, this means that rates will increase by 1.9 percentage points, or 31 percent, between 1975 and 1990. Further increases could cover the HI trust fund deficit, but might have adverse effects on employment, since the costs to employers of hiring workers would rise. Moreover, social security payroll taxes are already accounting for an increasing share of total Federal revenues—rising from 26 percent in fiscal year 1980 to 33 percent in 1988—and this approach would exacerbate this trend.

General revenue financing.—General revenues could be used to aid HI, as well as to maintain SMI at its projected levels. Medicare benefits, unlike social security retirement benefits, are not related to the amount of payroll contributions made by beneficiaries, and hence might appropriately be financed by taxes from all sources. This approach would not change the overall tax burden compared to increased payroll tax rates, however; it would merely redistribute it. Moreover, the projections of continued high Federal deficits imply that higher taxes of various sorts might be needed to replace revenues used to finance medicare.

CONCLUSION

The projected growth in medicare outlays poses problems for controlling the Federal deficit and for insuring the solvency of the HI trust fund—a problem whose magnitude, without changes in current law, will continue to expand for the foreseeable future. The size of reductions in outlays or increases in taxes that would be required to bring HI into balance over time suggest the importance of considering a combination of approaches to spread the burden among providers, beneficiaries, and taxpayers. For example, if the HI deficit were to be eliminated only through lower benefits, medicare beneficiaries would have to pay a coinsurance rate of 33 percent on hospital days 2 through 60 by 1995—a retrenchment in medicare that few would support.

In addition to these medicare-oriented approaches, a long-term solution to the problem of rising medical care costs would probably require changes affecting the entire medical care system. Efforts to enhance competition—even if not directly affecting medicare—might ultimately accomplish some systemwide cost reductions. For example, limits on the amount of tax-free medical benefits that employers may provide could help discourage excessive use of medical services and lead to slower growth in prices for all users of medical care. In addition, paying hospitals through some form of prospective system could be instituted for all payers—rather than just for medicare. Such approaches would add an additional set of options—but ones that would affect all participants in the health care system.

Thus, the available options can be placed in three groups, each of which poses difficult tradeoffs. Raising taxes could leave medicare intact but only at considerable cost to taxpayers. Obtaining savings exclusively through increased medicare cost-sharing or reduced reimbursements could lead to a second-class system of care for the aged and disabled. Systemwide attempts to contain medical care costs could ultimately result in slower expansion in services to most users of health care, although the impact on health care is unpredictable.

APPENDIX

The following table displays a number of options for reducing HI and SMI outlays from the Congressional Budget Office publication "Reducing the Federal Deficit: Strategies and Options," as well as preliminary CBO reestimates of the administration's budget proposals that were discussed in the text. These alternatives are meant to be illustrative; in practice, the stringency of the options could be varied to produce more or less savings.

The savings resulting from the different options cannot be added to a grand total. Many of them are alternatives, only one of which could be enacted. Furthermore, even if a nonoverlapping group of them were enacted, some would interact with others in ways that would produce results different from those estimated for each option separately.

BUDGET SAVINGS FROM PROGRAM CHANGES IN MEDICARE

[Outlays in billions of dollars]

Options	1984	1985	1986	1987	1988	Cumulative 5-year savings
Change physician reimbursement:						
Limit reasonable charge growth [1]	([2])	0.2	0.6	1.1	1.7	3.6
Adopt fee schedules for surgical procedures [3]	.2	.7	.8	.9	1.1	3.6
Administration's proposal for freezing physician reimbursement [4]	.9	1.1	1.2	1.4	1.6	6.1
Increase beneficiary cost-sharing:						
Expand hospital coinsurance days 2 through 30 [5]	2.0	3.0	3.4	3.8	4.3	16.5
Expand hospital coinsurance with cap on out-of-pocket costs for some [6]	1.2	1.8	2.1	2.3	2.6	10.0
Administration's proposal to expand hospital coinsurance [7]	.9	1.5	1.8	2.0	2.3	8.4
Increase SMI premiums [8]	.9	1.1	1.7	2.5	3.4	9.6
Increase SMI premiums for high-income families only [9]	.2	.3	.5	.7	.9	2.5
Administration's proposal to increase SMI premiums [10]	.2	.2	1.3	2.8	4.5	8.6
Increase taxes: [11]						
Raise payroll taxes [12]				2.9	4.0	6.9

[1] Growth in reasonable charges would be limited to the rate of increase in the overall Consumer Price Index.

[2] Less than $50 million.

[3] Fee schedules for surgical procedures would be set so that allowed charges were reduced by 10 percent.

[4] Reimbursements for physicians' services would be frozen in 1984 at their 1983 levels.

[5] Hospital coinsurance would be set at 10 percent of the deductible for days 2 through 30, replacing current coinsurance; there would be no limit on the number of covered hospital days.

[6] Hospital coinsurance would be set at 10 percent of the deductible for all hospital days after the first, and total HI and SMI cost-sharing liability for beneficiaries with family incomes of less than $20,000 would be limited to $2,000.

[7] Hospital coinsurance would be set at 8 percent or 5 percent on days 2 through 60 in a given year, replacing current coinsurance; there would be no limit on the number of covered hospital days.

[8] SMI premiums would be increased to 30 percent of average incurred costs for an elderly beneficiary.

[9] SMI premiums would be increased to 30 percent of average incurred costs only for beneficiaries with family incomes in excess of $20,000.

[10] SMI premiums would be increased gradually to 35 percent of incurred costs, but with an initial delay in any change until Jan. 1, 1984.

[11] Similar levels of tax increases could be achieved through general revenues.

[12] Payroll taxes would be increased in 1987 by 0.1 percentage point, to 1.55 percent each, for employers and employees.

Senator **PERCY**. Senator Burdick, did you make an opening statement?

Senator **BURDICK**. No.

Senator **PERCY**. Would you like to at this time?

Senator **BURDICK**. No; I have some questions, but I will wait.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator **PERCY**. Fine. I would like to make an opening statement. But first, I would like to say how pleased I am to be with you again. The only regret I have is that I could not go on the Budget Committee because of the rules of the Senate; I had too many other committees. As the principal Republican sponsor of the Budget Act of 1974, I have watched with tremendous interest the development of the Congressional Budget Office under your direction. I do not know how the Senate ran without it, and not only in the whole area of budget, but your expertise and analysis of problems is absolutely invaluable.

Dr. **Rivlin**. Thank you very much, Senator.

Senator **Percy**. And your own personal devotion to your work has been a tremendous source of inspiration to all of us.

Turning now to the purpose of this hearing, for those of us who thought that putting social security back on a sound financial footing was our biggest problem, I think it has come as quite a shock to us, and a great disappointment, that when we review the problem of medicare now, the problem is both immediate and it is astounding. The deficit is expected in the hospital insurance trust fund by 1987, less than 4 years away, and if we do nothing beyond current law, we will face a deficit of $300 to $400 billion by 1995. According to your office, the projected growth in outlays for hospital care is due primarily to rising hospital costs and to a lesser extent, the aging of the population. Rising hospital costs account for 10.8 of the 13.2-percent annual projected growth for 1982 to 1995, while covered earnings during the same period, that is, the base for revenues coming into the system to support these outlays, are expected to grow at an annual rate of only 6.8 percent.

This is nothing less than a recipe for disaster. This year, as part of the social security bill, Congress took a first step at addressing this problem by enacting a prospective payment system for hospitals that provide services to medicare beneficiaries. This new system of payment is supported by hospitals and should be helpful in controlling medicare costs. But obviously, based on the CBO report, much more needs to be done in the near future to bring outlays in line with revenues. We essentially have three choices. We can increase revenues by raising the medicare part of the payroll tax or raise special taxes and earmark them for medicare. We can increase beneficiary cost sharing, or we can further limit provider reimbursement—or, we can use a combination of all three.

It is imperative that we act, just as we did with social security, to preserve the medicare program. It provides assistance to 26 million elderly Americans in this country and 3 million disabled persons. In 1983, 68 percent of all beneficiaries had estimated family incomes of less than $20,000 per year. Median household income of aged medicare beneficiaries in 1981 was $10,447 per year. In the same year, per capita personal health expenditures for the elderly were $3,140. Medicare covered 42.5 percent of that bill. For this reason, I am delighted that Chairman Heinz has held these hearings, to bring everyone's attention to the scope of this problem and the need for consideration of reform measures, including the administration's fiscal year 1984 budget proposal.

I would like to turn now to Senator Burdick and ask if he would care to ask questions. I will follow with my own questions, and if Senator Heinz is not here by the time I finish my own, then I will ask you questions that he has left for me.

Senator **Burdick**. Thank you, Mr. Chairman.

Dr. Rivlin, welcome to the committee.

Dr. **Rivlin**. Thank you.

Senator **Burdick**. Many medicare beneficiaries are already living close to the poverty line. Do you have any statistics as to how much increased cost sharing they can absorb before they will be so poor as to qualify for medicaid? Do you have any figures showing a relationship between an increase in medicare cost sharing and an increase in medicaid costs? How soon does increased cost sharing begin to cost the Government more in medicaid than we save in medicare?

Dr. **Rivlin**. That is an interesting series of questions. I think for a detailed answer, we would like to provide statistics for the record. You are quite right in pointing out that there is a strong relationship between the two programs. Many of the poorest of medicare recipients or beneficiaries are also covered by medicaid, so that any increase in cost sharing for them does result in increased costs for medicaid.

The question, as you point out, is how many people are not yet poor enough to be covered by medicaid but might be if they had to pick up additional medicare cost sharing. I think, unless one of my colleagues wants to volunteer something, we will give you an answer for the record.

Let me introduce Dr. Paul Ginsburg.

Dr. **Ginsburg**. Let me just give you one fact, that about 15 percent of medicare beneficiaries already are eligible for medicaid, so for that group, cost sharing would be automatically picked up by the medicaid program. Certainly, there is a large group that is not that far above the income line for eligibility for medicaid. In States that provide medicare benefits for the medically needy, any substantial increase in cost sharing would, therefore, increase the medicaid population.

Senator **Burdick**. Now, if you would care to further elaborate and expand on the answer for the record, I would appreciate it.

Dr. **Rivlin**. We will do that.

[Subsequent to the hearing, Dr. Rivlin supplied the following information:]

In 1981, 18 percent of all households headed by someone over the age of 65 were in poverty. For an elderly couple, for instance, the poverty income threshold was $5,500. Almost 30 percent had incomes less than 125 percent of the poverty level—$6,875 for an elderly couple. The income picture for elderly and disabled families—and hence the number in poverty—is not expected to be much brighter in 1984.

Even among such low-income families, however, not all are eligible for medicaid. Recipients of supplemental security income are generally eligible and such families usually have incomes somewhat below the poverty line. At States' discretion, another group—the medically needy—may be covered if they have large amounts of medical expenses relative to their incomes. It is the size of this latter group which would be most likely to expand if cost sharing were increased under medicare. Since only 34 States have programs for the medically needy, increases in medicaid eligibility would be limited, however.

In addition, under most options being discussed, the actual number of beneficiaries whose cost sharing would rise sufficiently to make them eligible for medicaid assistance as "medically needy" in any year would be quite small, so that any change in the medicaid population would not be quite small, so that any change in the medicaid population would not be great. Out-of-pocket medical care costs might have to rise by $1,000 or more to make "near-poor" households eligible for medicaid. As an example, if hospital coinsurance were extended to cover all days and set at 10 percent of the HI deductible amount, persons with hospital stays of 30 days or longer would experience cost-sharing increases in excess of $1,000 in 1984. Only a small proportion of all beneficiaries have such extended stays, however.

Senator BURDICK. The administration has proposed increased cost sharing for beneficiaries with catastrophic protection. What percentage of medicare beneficiaries would lose protection under such a plan if a cap on cost sharing were set at $2,000? Are there large percentages of people who would spend almost up to the cap without exceeding it and just end up with large out-of-pocket costs? Would such a plan end up being a plus for the majority of people?

Is that another tough one?

Dr. RIVLIN. Another tough one. Let me get Dr. Ginsburg, and also Dr. Moon, back to the table, and we will pass this one to Dr. Marilyn Moon, who is the principal author of a CBO report on cost-sharing.

Dr. MOON. The catastrophic cap that is usually referred to is a certain level beyond which the Federal Government would pay all costs. In the case of the administration's proposal, the Federal Government would pay all of the coinsurance for hospitalization for beneficiaries who were hospitalized more than 60 days. Only a very few beneficiaries would fall into this category, but they are people who have very large expenditures out-of-pocket. Under the administration's proposal, this cap would be combined with greater hospital coinsurance on shorter stays, thereby increasing costs for about one-fourth of all beneficiaries.

Alternatively, if you put a $2,000 cap on combined part A and part B cost sharing, that would affect approximately 5 percent of all medicare beneficiaries in any given year. This option would have a considerable impact, however, on the costs to the Federal Government, since the average out-of-pocket costs for this 5 percent of beneficiaries, are quite high now. On the other hand, introducing a very large deductible of $2,000 for combined medicare expenditures—which, if I understand your question, may be what you are asking—would have a great impact on cost-sharing for individuals, raising their liability substantially.

Senator BURDICK. Dr. Ginsburg, would you care to comment on this?

Dr. GINSBURG. No; I think she has done it well.

Senator BURDICK. You think she has taken care of it. Thank you.

Do you have any ideas for alternative forms of health care that look to be real money savers for medicare? Do you have any figures showing that increased home health care, for instance, could make any appreciable savings? And I might say that we have had hearings on home health care, and I have conducted some of them, and I think there is a lot of promise there. But have you cranked that into the figures of cost the possibility of expanding home care?

Dr. RIVLIN. We have not cranked that into these estimates, but I think you are right that there are possibilities there. Let's get some more comment on that.

Dr. GINSBURG. Many people believe that greater use of home health care would result in lower costs for long-term care, in total. But one problem is that this may not necessarily reduce Federal or State outlays for long-term care. The main obstacle is that if we were to expand financing for home health care, many of those who are currently paying for it from their own pockets, or are using the services of friends and relatives, might very well apply for benefits.

In many cases, expanding financing for home care, would increase Government outlays even though it would reduce total costs.

Senator BURDICK. Well, I notice you have given the committee four alternatives to make some corrections for the future. You do not prefer any of the alternatives, I notice, but I suppose the committee will be discussing them in the days ahead.

Thank you, Mr. Chairman.

Senator PERCY. Thank you very much, Senator Burdick.

I mentioned in my opening statement the prospective payment system, and I have discussed it with a great many hospitals in Illinois, ranging from the most affluent to one that we just reopened in East St. Louis just last weekend after it had been endangered. I find universal support and hope for this system by the hospital administrators. I wondered whether you think it will be effective? Will it provide some of the solutions to our problem of rising costs?

Dr. RIVLIN. I think it is a good step forward. After a lot of discussion of the problem, finally, we have on the books a change in reimbursement that moves the Federal Government from simply paying the incurred costs to paying prospectively. This gives hospitals an incentive to get their costs down. It is not an easy thing to work out, because inevitably some hospitals have higher costs than others, for reasons that are not related to efficiency. It costs more to run a hospital in downtown Chicago than in rural Illinois, obviously, and the difficulty of putting together a law that would give the right reimbursements without penalizing hospitals for costs that are higher through no fault of their own has been the basic problem.

Whether the current law will exactly do that is not clear. I think it is a good start. We will have to evaluate the information that comes in about hospital costs as we move along and see if adjustments are needed in the law to improve its effectiveness. But it seems to me it is a fine start.

Senator PERCY. Well, we have known for some time that there is an imbalance between revenues and expenditures in the hospital insurance program, and we have enacted increases in taxes to take effect in future years, to make up projected shortfalls. Why now, in your judgment, Dr. Rivlin, is the deficit problem only a few years away? Where did we fall down? Where did the system fall down that we are once again at sort of a crisis stage here? Was it the executive branch that should have taken action before this? Should we have anticipated these rising costs? Were we at fault here in the Congress? Who fell down? What has happened to accelerate the hospital insurance trust fund problem?

Dr. RIVLIN. Probably everybody shares a bit of the blame, but I am not sure too much blame is in order. One can only deal with a certain number of problems at once, and a lot of attention was focused on the social security cash outlay problem, which was more immediate. Consequently, there was some shunting aside of concern with the HI trust fund.

Some of the reasons are the same ones that caused the trouble with the social security fund; we economists simply did not anticipate that the economy would be faced with a prolonged period of low growth in wages, which provides the revenues for the trust fund, and high inflation, which is part of the reason for the rising hospital costs. Nobody anticipated that.

Senator **Percy**. So the recession, really, is part of the factor that brought on——

Dr. **Rivlin**. Well, it has been slow growth in wages plus, until very recently, high inflation; it is the combination of those two things. Then, in the case of the hospital insurance trust fund, it is also the continued increase in the use of services and in the elaborateness of those services. The mix of services has shifted more toward expensive procedures. That has been going on for some time, but I think it has caught up with us now, in part because of the overall deficit problem. Finally, for a long time, Congress seemed willing to raise the taxes for HI to make up for the rising costs, but we have now reached a point where overall tax rates are very high, and there is a reluctance to stay on that track.

Senator **Percy**. I would appreciate your analysis of one of the remedies that would have to be used—increased payroll taxes to help meet this deficit. Is this sort of a self-defeating thing? Our biggest problem is unemployment; that is contributing to the problem. But if we raise payroll taxes, what effect does that have on our ability to keep fighting the problem of unemployment?

Dr. **Rivlin**. At the margin, an increase in payroll taxes makes it slightly more expensive for a firm to hire additional workers, and that is obviously not a very good thing to do when you are worried about unemployment. On the other hand, some of the other choices are not that great, either, so that as between having a larger deficit and increasing taxes, one might well choose to increase taxes.

Senator **Percy**. How much would payroll taxes have to go up to make up the entire projected deficit?

Dr. **Rivlin**. Quite a lot. Do we have an estimate on that one, Paul?

Dr. **Ginsburg**. Yes.

Dr. **Rivlin**. As I remember it, the tax rate would have to double, from 1.3 to well over 2 percent.

Dr. **Ginsburg**. That is right. Currently, the HI payroll tax is scheduled to rise in 1986 to 1.45 percent for both employers and employees and stay at that level. In order to maintain solvency, this tax would have to go up every year beginning in 1988. By 1995, we calculate it would have to be about 2.4 percent each.

Senator **Percy**. Thank you.

Dr. **Ginsburg**. That is, 2.4 percent of payroll for both employers and employees.

Senator **Burdick**. That is 4.8 in total?

Dr. **Ginsburg**. That is right.

Senator **Percy**. That is a stiff increase.

The administration has proposed coinsurance coupled with catastrophic coverage to protect beneficiaries from the costs associated with long hospitalization. Rather than using coinsurance, could we not link such coverage to a premium to be paid monthly by all medicare beneficiaries? If so, how high would a monthly premium have to be to provide the catastrophic coverage recommended by the administration?

Dr. RIVLIN. That would clearly be an option. It would shift the cost to everybody who is enrolled in HI, rather than just to those who are hospitalized.

Do we have an estimate on what the level would have to be to do that?

Dr. MOON. It would be about $4 per month, if it were mandatory; $4 per month would approximately pay for all of the costs of hospital coinsurance on stays beyond 60 days and for extending coverage to hospital days after the lifetime reserve is exhausted, for which medicare now pays nothing.

If it were not mandatory, the cost would probably have to be slightly higher, because those who would choose coverage would be those more at risk.

Senator PERCY. Thank you very much.

That completes the questions that I have. I would like to now begin to ask the questions that Senator Heinz left, so that the answers can be not just put on the record, but so our very attentive and standing room only group with us today as guests can also hear your response to these questions.

His first question is the following: What would medicare's financial picture be now if we had enacted the Carter hospital cost-containment proposals in 1977, or the Gephardt-Stockman and/or the Health Incentives Reform Act in 1979? Now, I think you are familiar with both of those proposals that were made. I know, whereas I mentioned enthusiasm by the hospitals for the prospective charges, we had an uproar at the time the Carter administration proposed the hospital cost containment in 1977. They just felt it would be totally unrealistic.

Dr. RIVLIN. It is hard to say exactly what would have happened. In general, however, if the Carter proposal had been enacted, medicare would be in better shape, although the proposal would not have solved the whole problem. We made an estimate in 1979 that enactment of that cost containment proposal would save about $8 billion over the period 1980 to 1984. If that turned out to be approximately right, they would be $8 billion to the good—and more over future years—but it still would not have solved the whole problem by any means.

It is even harder to say what the Stockman-Gephardt proposal would have done. At the time, we did not project that it would have resulted in a short-term improvement for medicare alone, although in the longer term, it would have taken some of the pressure off medical care prices and would probably have benefited medicare.

Senator PERCY. Senator Heinz' second question is as follows: Wouldn't changes in physician reimbursement, such as placing inpatient physician services under the new medicare prospective payment system, as well as the physician reimbursement changes that you mentioned, also have the effect of lowering hospital costs?

Dr. RIVLIN. They might, although again it is hard to say. Such changes might reduce the use of inhospital tests and other procedures, but we are not sure exactly by how much.

Let me see if Marilyn would like to add to that.

Dr. MOON. It is difficult to say. On the one hand, if you paid physicians a fixed amount, that might encourage them to restrict the amount of services and procedures that they undertake in a hospital. If so, the hospital would benefit as well. On the other hand, physicians would have an incentive to ask hospitals to take over some procedures or the supervision of procedures normally supervised by physicians themselves.

Senator PERCY. This is Senator Heinz' third question: Considering beneficiaries' current out-of-pocket expenses and income, to what extent can beneficiary cost sharing be expected to increase without adding significant barriers to care?

Dr. RIVLIN. Well, again, hard to say. Medicare only pays about 45 percent of the total costs of the elderly for health care. A lot of the rest is covered by private insurance that medicare beneficiaries have. Those premiums would rise, and some of it is covered by medicaid. So it is difficult to say exactly what the effects would be.

Marilyn, do you wish to add anything?

Dr. MOON. I think that pretty well summarizes it.

Senator PERCY. That is a good, diplomatic answer.

Dr. MOON. We know that by 1984 medicare beneficiaries will pay about $500, on average, and some of them will pay much more than that for the cost sharing that is associated with medicare. So, in many cases, increased cost sharing would substantially raise the out-of-pocket costs of the elderly, although some of these costs would be covered by private insurance, which would instead result in higher premiums.

Senator PERCY. Finally, regardless of the fact that adding revenues will not address medicare's high trust fund basic problem, the growth of hospital costs, do you think that some revenue increases will be needed?

Dr. RIVLIN. It is hard to see how all of these problems could be solved in the short run by either increased cost sharing by the beneficiaries or lower payments to providers, so that certainly, to buy time for working out a better system, one might well argue for an increased tax rate.

Senator PERCY. Thank you very much, indeed. Your testimony has been extremely helpful, you and your colleagues, and we appreciate your being here with us very much indeed.

We will keep the record open in the event that there are other questions that members of the committee who could not be with us today would have for you.

I would very much appreciate your extending my deep appreciation to the Congressional Budget Office staff. It is an absolutely outstanding staff, highly professional. Their services to us, as I have said, are just absolutely invaluable. I have had great satisfaction from watching the evolvement and the development of CBO as a cost-effective department, I think second only to IRS, probably, and the Comptroller General—I think the Comptroller General's Office is extraordinarily cost effective. You must return 10 to 1, 20 to 1, 30 to 1, 50 to 1—I do not know what it is—but the rate of return on investment that we pay for staff, and so forth, is just absolutely remarkable. And I just want you to know I sleep better nights knowing that we have that system and that we have our own Congressional Budget Office. And when I consider the courageous positions taken by the CBO, particularly at times when assumptions that are underlying might be basically different, and you have stood up and taken the gaff, and been proven right quite a few times. I really am proud of what you have done.

Thank you very much.

Dr. RIVLIN. Thank you very much, Senator. It is speeches like that that make it all worthwhile.

Senator PERCY. Our next witness is Dr. Carolyne K. Davis, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services.

Senator Burdick, would you be able to chair the hearing—I can stay another 10 minutes.

Senator BURDICK. Yes, I will be back in 10 minutes.

Senator PERCY. That would be wonderful. I really appreciate it very much.

Dr. Davis, I will ask if you could possibly confine your summary to 10 minutes. Then, I will have to leave, but Senator Burdick will take up the chair until Senator Heinz is able to return.

STATEMENT OF DR. CAROLYNE K. DAVIS, WASHINGTON, D.C., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY DR. GEORGE SCHIEBER, DIRECTOR, OFFICE OF POLICY ANALYSIS; AND PATRICE FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY

Dr. DAVIS. Thank you, Senator Percy.

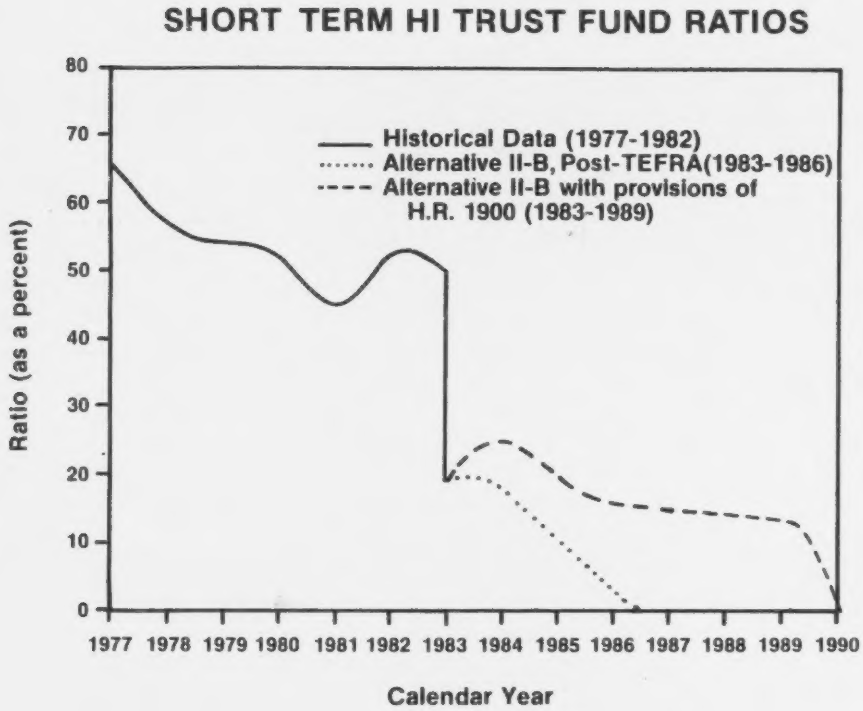
Let me introduce my colleagues who are at the table with me. On my left is Dr. George Schieber, who is the Director of the Office of Policy Analysis, and on my right is Patrice Feinstein, who is my Associate Administrator for Policy, in the Health Care Financing Administration.

I am very happy to be here today to discuss the long-term financing in medicare's trust fund and some of our key reform proposals.

As you well know, the prospective payment system was part of the administration's health incentives reform program. It was recently passed as a first step in improving the solvency of the hospital insurance—HI—trust fund. With passage of the prospective payment system and enactment of some other kinds of recommendations, we have some improvement in the short-term situation in our hospital insurance trust fund.

The last formal report by the trustees to Congress was in April 1982. As noted on chart 1 by the smaller dotted line, that report indicated that the HI trust fund would go broke in either 1986 or 1987. Since that time, we have had borrowing from our hospital insurance trust fund through SSA use of interfund borrowing. Additionally, we have the passage of both the Tax Equity and Fiscal Responsibility Act of 1982 and the Social Security Amendments of 1983. These events have affected the short-term hospital insurance trust fund ratio such that, as indicated by the dashed line on chart 1, the hospital insurance trust fund will be depleted by 1990 using II-B assumptions, or by 1988 using the most pessimistic, alternative III assumptions.

CHART 1



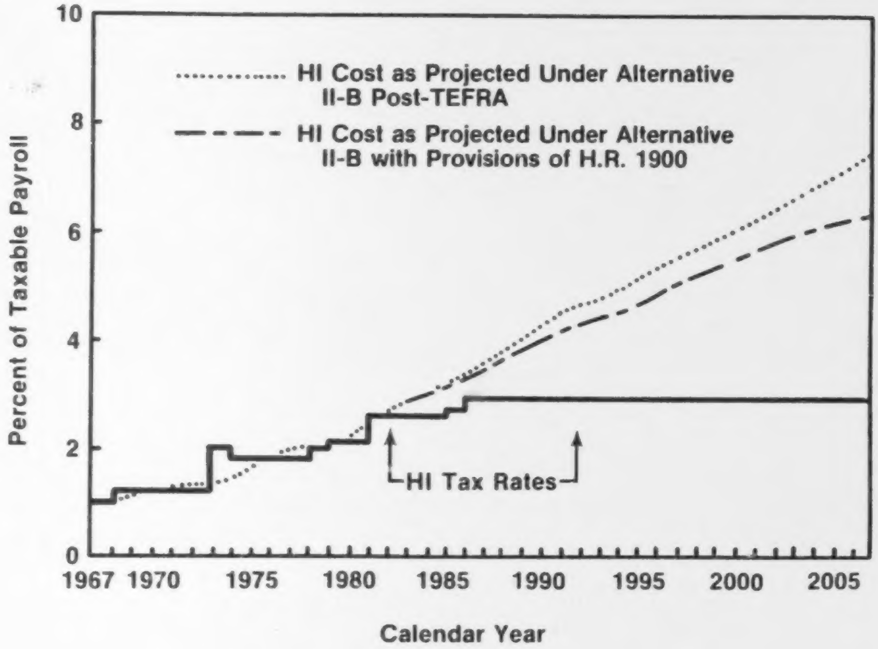
I would like to point out that the status of the trust fund, in terms of the trustees' report, has been a similar situation over the last 5 years. I believe that the 1977 trustees' report indicated that the solvency of the HI trust fund would be getting to the point of break even around 1990. But I think it is particularly important that we highlight these events now.

We believe that it is important to look at the short term and the long-range solutions. Our new estimates do include the factoring in of the prospective payments system and its impact on hospitals; the schedule for the loan repayment from the social security trust fund; and the lump-sum military wage credit transfers.

In chart 2, our long-term picture for a 25-year period indicates that the average cost of the program as a percentage of payroll is approximately 4.3 percent, and the current tax law rate for that period will be 2.8 percent. So, in terms of the program costs, we must either reduce the program costs by approximately 33 percent or increase the hospital insurance payroll tax by about 50 percent, or use some combination of the two, in order to keep the trust fund solvent over a 25-year period. But I would stress that that is over a 25-year period.

CHART 2

ESTIMATED HI COST AND TAX RATES

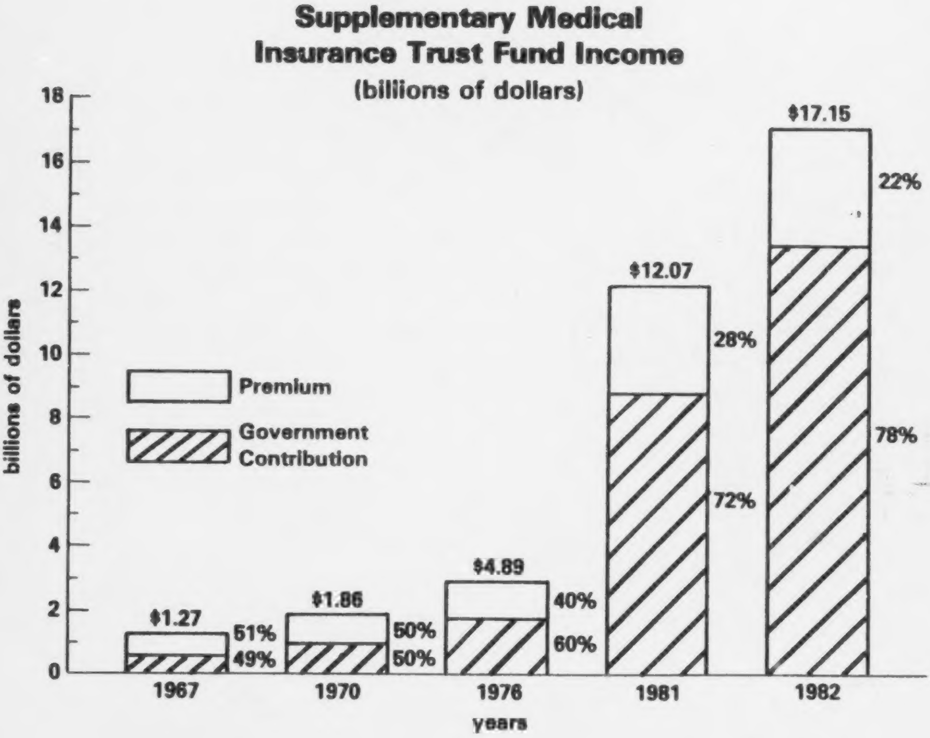


We do have a Quadrennial Advisory Council on Social Security that this year is analyzing the fiscal problems of the HI trust fund, and trying to explore the long-range solutions. The Council began last November, and its report is due to Congress by January 1, 1984.

If I could now briefly highlight some of the new proposals that we have in our budget this year which, if passed, would give us an additional year before the trust funds would be insolvent.

Before I do that, let me refer you to chart 3 and mention that although most of our discussion has centered on the HI trust fund, I would like to comment on the supplementary medical insurance trust fund. A large portion of the balance in that fund is due to the transfer from general revenues. I would just like to indicate that since the start of the program, the proportion of general revenue funding has been increasing, so that the initial 50/50 split between the premium contribution and the general revenue contribution has, as of 1982, diminished so that the premium contribution is 22 percent of the outlays, with 78 percent coming from general revenue. I will come back to chart 3 later.

CHART 3



Let me turn to the health policy reform areas now. In thinking about the activities that are needed to reduce our expenditures, we believe that we need to think of the system as a total system——

Chairman HEINZ [resuming chair]. Dr. Davis, may I interrupt you just for a moment?

Dr. DAVIS. Surely.

Chairman HEINZ. I know Senator Percy has to go and chair another committee. I want to thank him for, in my absence, having chaired and so ably chaired, this committee, which for many years, he was the ranking member on, and would have been chairman if there had been enough Republican Senators to make him chairman—Mr. Chairman, thank you very much.

Senator PERCY. Well, Mr. Chairman, every year that goes by, I get more interested in the Aging Committee. [Laughter.]

And pretty soon, in 3 more years, I will have a conflict of interest or, as Senator Dole would say, "no conflict, just interest."

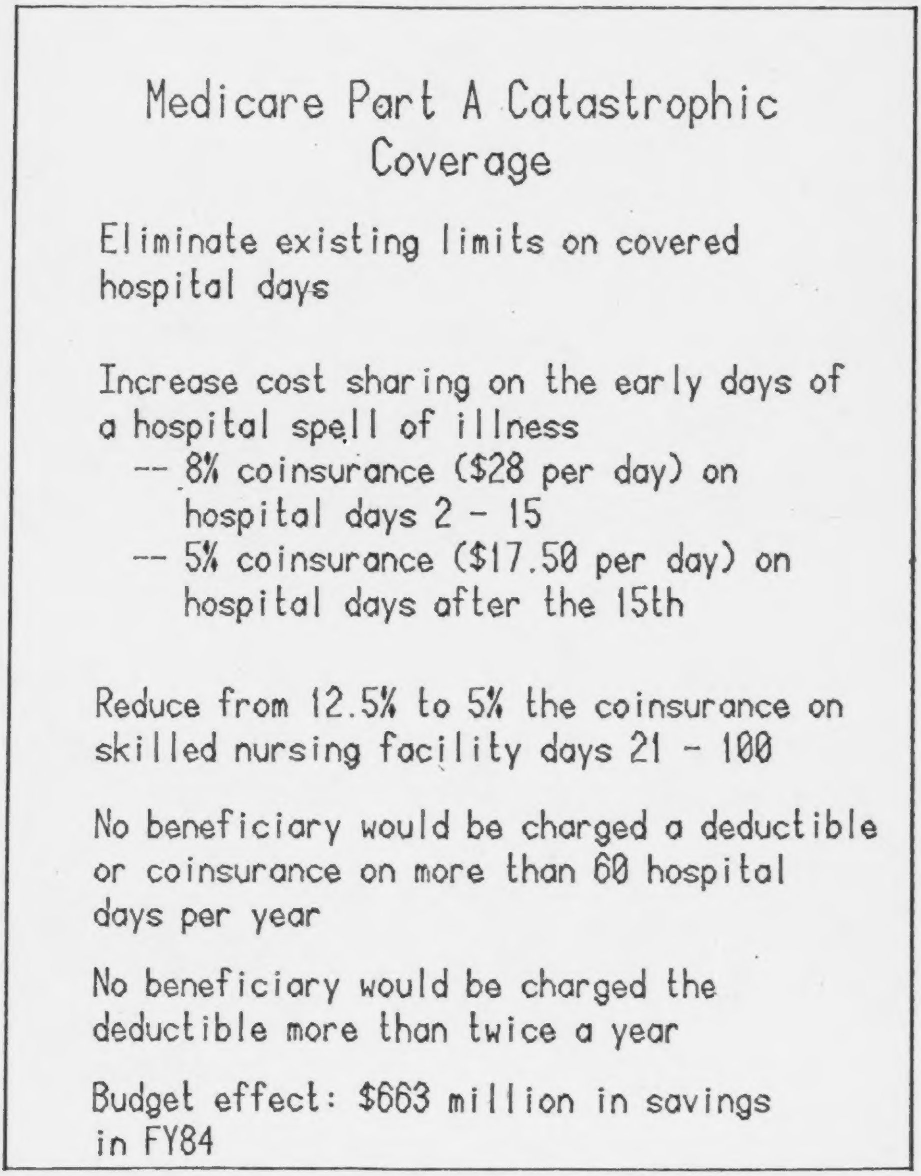
Chairman HEINZ. Senator Percy, thank you very much.

Dr. Davis, please proceed. I apologize for interrupting you.

Dr. DAVIS. If you think about this system as a whole, there are really three total parts of the system—the patients, the providers, and the third-party payers. We believe it is important to look at the system and to design incentives to change the behavior on the part of all of those components. And our incentive package this year does concentrate on these specific areas.

The first proposal, highlighted on chart 4, is medicare part A catastrophic coverage. This proposal would eliminate the existing, covered hospital days and move to increase cost-sharing in the early days of the hospital spell of illness, with 8 percent coinsurance on hospital days 2 through 15, and 5 percent from the 15th through the 60th day. In addition, it would reduce from the current 12.5 to 5 percent the coinsurance that a beneficiary pays in a skilled nursing facility on days 21 through 100. No beneficiary would be charged the deductible and coinsurance for more than 60 hospital days a year, and no beneficiary would be charged a deductible more than twice a year, even if they were hospitalized more than twice during the year. We believe the incentive here is to better protect the most seriously ill patients, who are hospitalized the longest, and during the early days of the hospital stay, to give an incentive for the individual, working with the providers to decrease the total days that they are in the hospital.

CHART 4



Medicare Part A Catastrophic Coverage

Eliminate existing limits on covered hospital days

Increase cost sharing on the early days of a hospital spell of illness
- -- 8% coinsurance ($28 per day) on hospital days 2 - 15
- -- 5% coinsurance ($17.50 per day) on hospital days after the 15th

Reduce from 12.5% to 5% the coinsurance on skilled nursing facility days 21 - 100

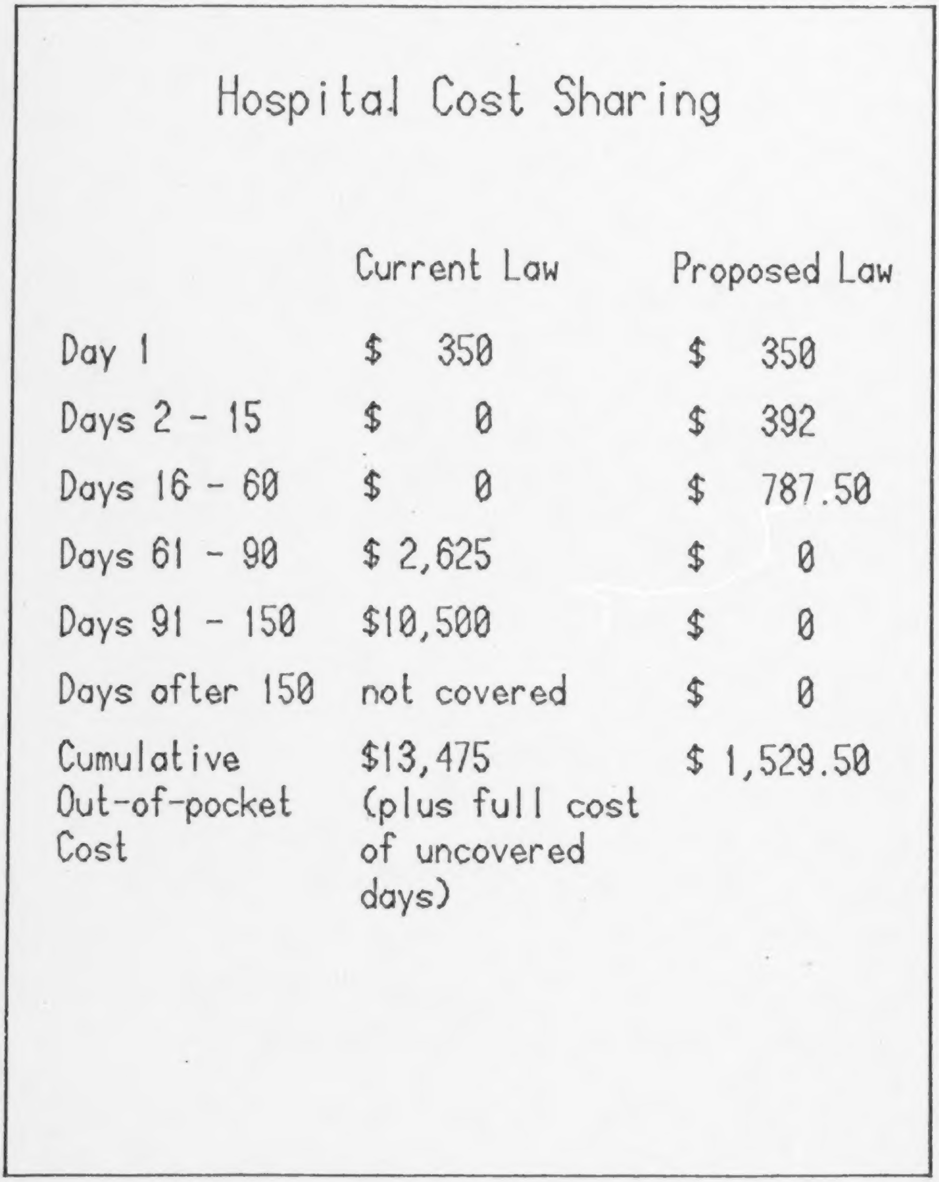
No beneficiary would be charged a deductible or coinsurance on more than 60 hospital days per year

No beneficiary would be charged the deductible more than twice a year

Budget effect: $663 million in savings in FY84

An example of protecting those seriously ill individuals is presented in chart 5. Under current law, if an individual stayed, let us say, 150 days in a single spell of illness, the beneficiary would be liable for out-of-pocket costs of at least $13,475. Under this proposal, the same beneficiary would only need to pay about $1,529 in out-of-pocket costs.

CHART 5



Hospital Cost Sharing

	Current Law	Proposed Law
Day 1	$ 350	$ 350
Days 2 - 15	$ 0	$ 392
Days 16 - 60	$ 0	$ 787.50
Days 61 - 90	$ 2,625	$ 0
Days 91 - 150	$10,500	$ 0
Days after 150	not covered	$ 0
Cumulative Out-of-pocket Cost	$13,475 (plus full cost of uncovered days)	$ 1,529.50

The next proposal summarized on chart 6, is a physician fee freeze. Last year, as you know, we worked very diligently on a change in our reimbursement system for hospitals. That has taken a great deal of our time and effort and involved about 1½ years of intensive activity. We believe it is important to freeze the medicare reimbursements to physicians, because it is the second largest component in medicare spending. During 1983, part B expenses are estimated to increase at the rate of approximately 19 percent. We think that we probably need to study restructuring the physicians' fee system, but it would take time to do this, so we are proposing an interim measure—a physician fee freeze.

CHART 6

Physician Fee Freeze

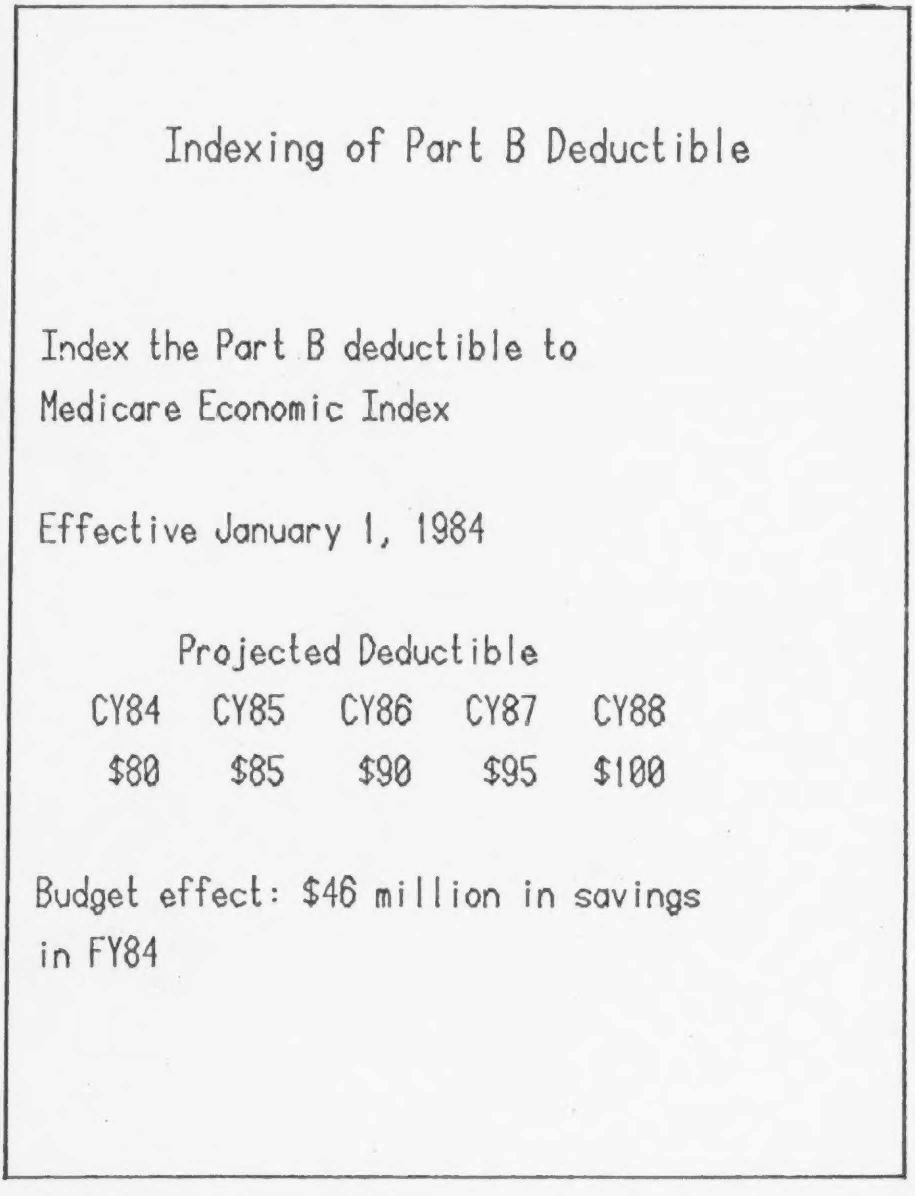
Freeze Medicare reimbursements to physicians

Effective from July 1, 1983 through June 30, 1984

Budget effect: $100 million in savings in FY83 and $700 million in savings in FY84

In addition to that, in terms of the supplementary medical insurance trust fund, we are proposing that to index the part B deductible. That index has remained constant in its dollar value, and that lessens its influence as a deterrent to increased utilization. We think it is important to index the part B deductible to the medical economic index so that the real dollar value is maintained. As you can see from chart 7, that would become effective January 1, 1984, and in actuality, the projected increase in the deductible would amount to only a few dollars each year.

CHART 7



Indexing of Part B Deductible

Index the Part B deductible to Medicare Economic Index

Effective January 1, 1984

Projected Deductible

CY84	CY85	CY86	CY87	CY88
$80	$85	$90	$95	$100

Budget effect: $46 million in savings in FY84

Chairman **Heinz**. Dr. Davis, just a question for clarification. That is what you would project if your proposal were adopted.

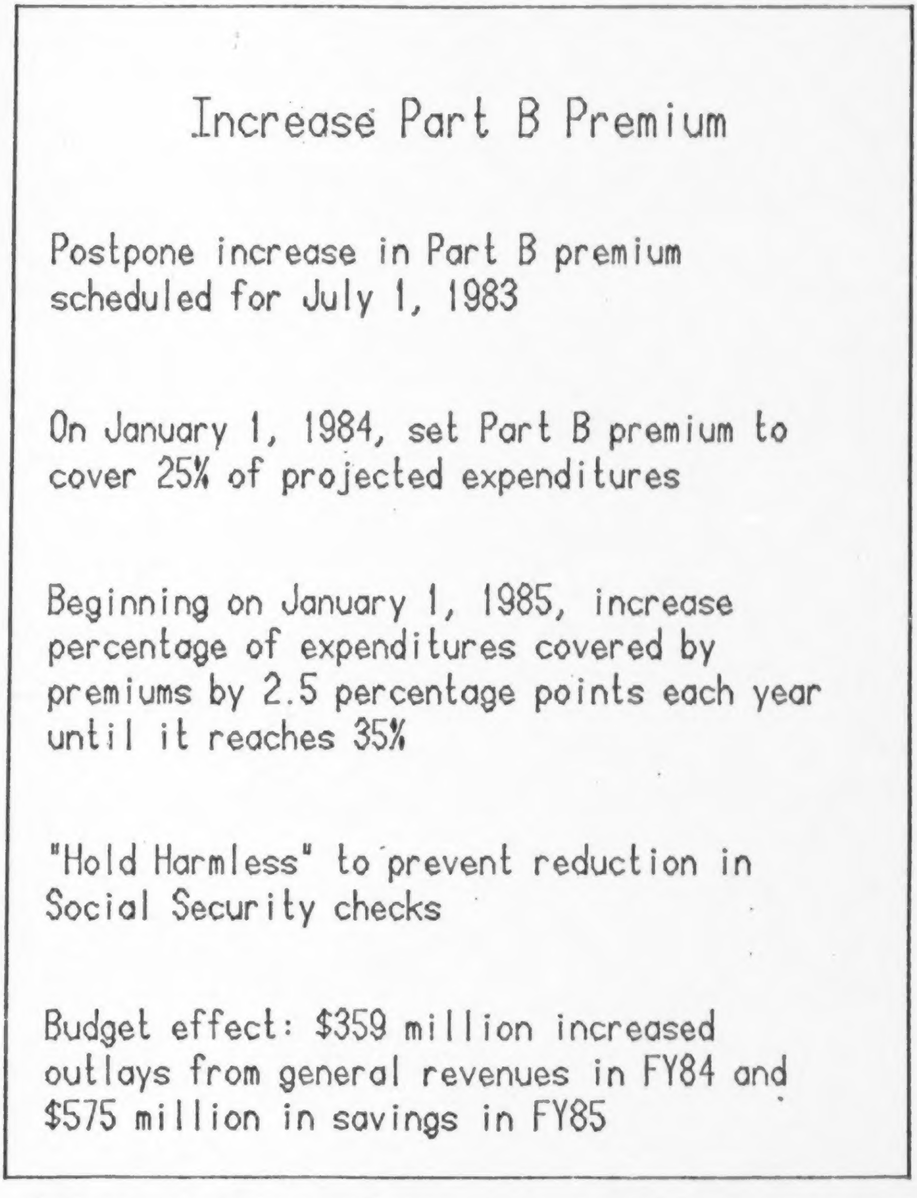
Dr. **Davis**. That is correct.

Chairman **Heinz**. What would the numbers be if your proposal was not adopted? Part B at this point is indexed just to the CPI.

Dr. **Davis**. It is a fixed, $75 deductible.

Chart 8 is the very one I think you were thinking about. It shows the increase in the part B premium.

CHART 8



Increase Part B Premium

Postpone increase in Part B premium scheduled for July 1, 1983

On January 1, 1984, set Part B premium to cover 25% of projected expenditures

Beginning on January 1, 1985, increase percentage of expenditures covered by premiums by 2.5 percentage points each year until it reaches 35%

"Hold Harmless" to prevent reduction in Social Security checks

Budget effect: $359 million increased outlays from general revenues in FY84 and $575 million in savings in FY85

Referring back to chart 3 for a moment, you can see that originally the premium was a sharing, 50/50, between general revenue financing and the part which is paid by the beneficiary.

This proposal has three steps. The first one, postponing the increase in the part B premium that was scheduled for July 1, 1983 to January 1, 1984, was recently passed in the Social Security Amendments of 1983. The second step is to set the premium at 25 percent of the projected expenditures. Finally, beginning in January 1985, increase the percentage of expenditures covered by premiums by approximately 2.5 percentage points each year, until it reaches 35 percent.

One thing we would do, however, is indicate that there should be a hold-harmless provision to prevent a reduction in any individual's social security check as a result of this change. Because we are delaying the increase in the premium for the first year, budget outlays from general revenue funds would increase by $359 million, but in fiscal year 1985, there would be approximately $575 million in savings from this proposal.

Chart 9 simply indicates a schedule of the premiums under the current law and what would occur with the monthly premiums under the proposal. For example, in 1985, using current law, the premium would be $15.90, and under the proposed law, assuming a 2.5-percent increase, it would be $17.80.

CHART 9

Scheduled Part B Premiums

	7/1/83	7/1/84	7/1/85	7/1/86	7/1/87	7/1/88
Current law per month	$13.50	$15.20	$15.90	$16.60	$17.40	$18.20

	CY1983	CY1984	CY1985	CY1986	CY1987	CY1988
Proposed law per month (assumes enactment of Fee Freeze etc.)	$12.20	$14.20	$17.80	$21.70	$26.30	$31.60

Chairman **Heinz**. Excuse me, Dr. Davis. Those charts are extremely helpful and useful. I note that not all those charts are provided with the statement——

Dr. **Davis**. We would be happy to provide them for the record.

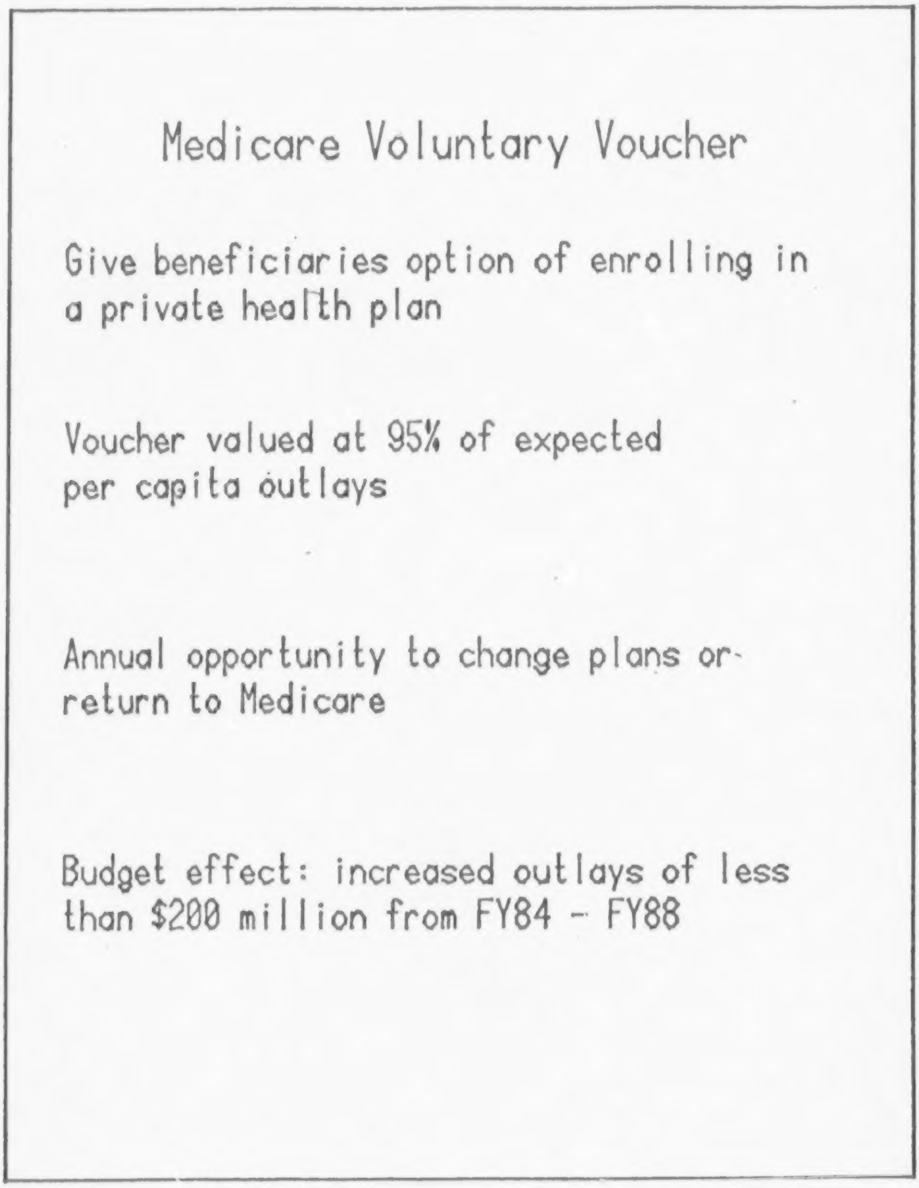
Chairman **Heinz**. Yes, if you could provide smaller versions of them, it would be appreciated.

Dr. **Davis**. Certainly.

Chairman **Heinz**. Thank you.

Dr. **Davis**. The medicare voucher proposal, summarized in chart 10, would give beneficiaries an option for enrolling in a wider array of private health plans. Last year, the Congress gave us permission to permit the HMO payments and to also permit some other competitive medical plans to go to a risk-based system. We believe that it would be desirable to broaden beneficiary choices even further. The voucher would be valued at 95 percent of the expected per capita outlays, which is another way of saying what it would cost to give that care to the beneficiary under the traditional coverage system.

CHART 10



Medicare Voluntary Voucher

Give beneficiaries option of enrolling in a private health plan

Voucher valued at 95% of expected per capita outlays

Annual opportunity to change plans or return to Medicare

Budget effect: increased outlays of less than $200 million from FY84 - FY88

There would be a requirement that at the minimum, each plan would have to provide the same level of services as is currently provided in parts A and B, and there would be an annual opportunity to change the plans or to return to medicare if the beneficiary wished to do so.

The next proposal, highlighted on chart 11, is really not part of our package in the Department, but is part of the administration's package, and that is a tax exclusion limit, or a proposal to limit the amount of tax-free insurance to $175 per month for a family, or $70 per month for an individual. Currently, the average cost is about $132 a month for a family, or $53 a month for an individual.

CHART 11

Tax Exclusion Limit

Limit the amount of tax-free insurance to

- -- $175 per month per family
- -- $70 per month per individual

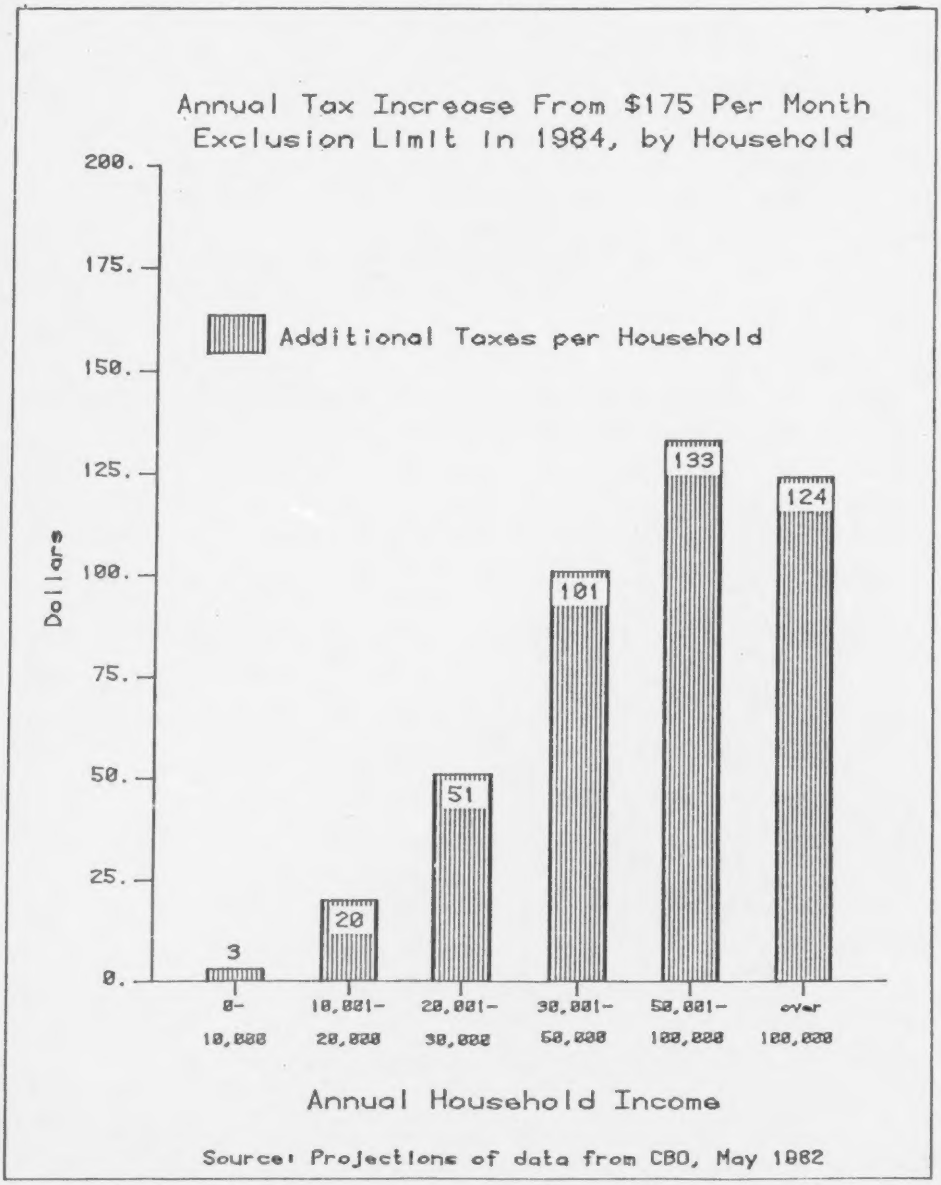
Excess is included in employee's taxable income

Budget effect: $2.3 billion in increased tax revenues in FY84

The excess over the $175 a month would be included in the employee's taxable income. And again, we believe that this is an important proposal.

Next chart 12 indicates what the additional tax increase would be on a $175 per month exclusion limit. You notice that it is progressive, that the higher the income is, the higher the amount of additional taxes that individual household will pay. For example, a household with an income of between $10,000 and $20,000 would pay a little less than $2 per month in additional taxes, whereas a family with an income between $50,000 and $100,000 would pay approximately $11 per month in additional taxes.

CHART 12



Source: Projections of data from CBO, May 1982

In summary, I believe that this particular grouping of proposals is complementary to the effort to constrain costs. They are all based upon incentives to change behavior, to enhance our cost awareness among all the various parties, and to improve the structure of medicare financing through providing catastrophic protection, and also, to enhance the opportunity for choices among the coverage plans and thereby stimulate additional competition. I

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think it is a strong beginning that does, indeed, provide us with some additional stability. But I must say that, as the Administrator of the Health Care Financing Administration and as the guardian of the HI trust fund in particular, I believe it is incumbent upon all of us to continue to search for ways to make the program efficient and economical. And we, obviously, are looking forward to the report from the Advisory Council on Social Security and to working with Congress in order to resolve the long-term financing problems. As I remember, chart 1 indicated that outlays must be reduced by either 33 percent or the revenue would have to be increased through the tax revenue system by doubling the HI tax, or some combination of both.

I think it is important to try to find a system that changes the behavior before we approach the necessity for moving to additional taxes as a support base for this.

Thank you, Mr. Chairman. That concludes my formal presentation.

Chairman HEINZ. Dr. Davis, thank you very much.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF DR. CAROLYNE K. DAVIS

I am very happy to appear today to discuss issues related to long-term financing of the medicare hospital insurance (HI) trust fund and some of our key reform proposals.

As you are aware, the prospective payment provisions, a major and critical piece of the administration's 1984 legislative proposal package, were recently passed by Congress as a part of the Social Security Amendments of 1983. This prospective payment approach is but the first step toward improving the financial foundation of medicare. I believe it is unnecessary to recite the data that show vividly how much hospital costs have risen over the past 15 years. I believe it is important to point out though that a part of the reason for the huge increase in hospital costs—far above the national rate of inflation—has been a retrospective cost-reimbursement system that rewards inefficiency. In constructing the prospective payment legislation, Congress removed the disincentives of the cost-based system and substituted instead a system which:

Is easy to understand and simple to administer.

Can be implemented in the near future.

Insures predictability of Government outlays and hospital revenues.

Establishes the Federal Government as a prudent buyer of services.

Assures that medicare expenditures for inpatient hospital services are no greater than the amount that would be spent if the present system of retrospective cost reimbursement with limitations were continued.

Provides incentives for hospital management flexibility, innovation, planning, control, and efficient use of hospital resources.

Reduces, over time, the cost-reporting burden on hospitals; and

Continues to assure beneficiary access to appropriate quality care.

Although the provisions in the social security amendments differ somewhat from ours, we believe that it still meets all of the objectives described above.

The passage of prospective payment, when coupled with the enactment of the National Commission on Social Security's recommendations, dramatically improves the short-term financial situation of the HI trust fund. Nevertheless, it does not solve the basic solvency issue as, even with the passage of these revisions, the fund will still be exhausted by the end of this decade.

This administration last submitted a formal report to the Congress on the financial status of the hospital insurance program in April 1982, when the annual trustees report was submitted. That report indicated that under current law, the HI fund would be depleted by 1987 under alternative II-B (intermediate) assumptions and by 1986 under more pessimistic alternative III assumptions. The 1983 report will be submitted once we have completed incorporating the details of the effects of the recent legislation.

However, I have attached recently developed HI fund projections using a variety of economic and legislative assumptions. These projections, which include prospective payment and provisions of the bipartisan agreement on social security reform which affect the HI program, indicate that the HI trust fund will not be depleted until 1990 under alternative II-B assumptions or 1988 under the more pessimistic alternative III assumptions. Additionally, assuming passage of the administration's 1984 medicare reform proposals, depletion of the HI fund would be further delayed until 1991 under the alternative II-B assumptions and until 1989 under the alternative III assumptions.

There are several reasons for these current law projections to be different from those provided in April 1982:

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made significant changes in the HI programs.

Recent enactment of the Social Security Amendments of 1983 have altered further the medicare HI program.

The HI trust fund loaned $12.4 billion to the old-age and survivors insurance (OASI) trust fund pursuant to the interfund borrowing provisions of Public Law 97-123 (which restored minimum benefits under the Social Security Act).

A projected schedule for the loan repayment is now included.

The military wage credits are also incorporated; and

A more pessimistic set of economic assumptions has been adopted.

Looking at the long-term picture, over an entire 25-year projection period from 1983 through 2007, the average cost of the program, expressed as a percent of payroll, will be 4.31 percent. During that same 25-year period, the average current law tax rate is 2.87 percent. In other words, either program costs will have to be reduced 33 percent or HI payroll taxes will have to be increased by 50 percent to keep the program solvent over the next 25 years.

As you know, the quadrennial Advisory Council on Social Security is currently analyzing the financial problems of the HI trust fund and exploring long-range options for resolution of these problems. This prestigious group began its work last November and will report its finding and recommendations later this year.

Now, I would like to review some of our other proposed reforms, since, as I have indicated, we believe these are a critical next step in insuring the continued viability of the HI fund. Our proposals are designed to change behavior for the better by removing perverse incentives for all sectors of the market—hospitals, physicians, consumers, employers, and insurers. When all the participants work together and share the responsibility for controlling costs, the future status of the HI fund should improve still more. The key remaining proposals of our "health incentives reform program" are: Restructured medicare hospital cost-sharing and catastrophic coverage, our voucher proposal, freezing physician reimbursement for 1 year, increases in the medicare part B premium, and indexing the part B deductible to the medicare economic index. I will now discuss each of these proposals in some detail.

RESTRUCTURED MEDICARE COST-SHARING AND HOSPITAL CATASTROPHIC COVERAGE

A major element in the administration's plan to correct system incentives is the proposal to restructure medicare cost-sharing. This proposal would promote cost-conscious decisions while protecting beneficiaries against catastrophic hospital expenses. Most importantly, it would put the protection where medicare beneficiaries need it most.

Under the current system, medicare hospital coverage is limited to 90 days per spell of illness and 60 lifetime reserve days. This places the greatest financial burdens on the sickest patients. Less severely ill patients, and their physicians, are given little incentive to keep their hospital stays as short as possible because patient cost-sharing, other than paying the deductible, does not begin until the 61st day of hospitalization.

The administration's proposal would change part A cost-sharing to create incentives for savings where those incentives can work and to better protect the medicare patient needing long hospitalization. Under the proposal, the beneficiary would pay the first day deductible provided for under current law and would then pay 8 percent of that amount—about $28 in 1984—for days 2 through 15 of hospital care in a spell of illness. For days 16 through 60 in a spell of illness, this amount would be reduced to 5 percent of the deductible—or about $17.50 per day. After the beneficiary had paid for 60 days of cost-sharing in a calendar year, there would be unlimited hospital days without additional cost-sharing.

In 1984, the proposal would cost a beneficiary $1,530 in out-of-pocket costs for a spell of illness with 150 hospital days compared with the $13,475 it would cost under current medicare provisions (even assuming the beneficiary had not previously used any lifetime reserve days). The proposal would provide medicare beneficiaries, for the first time, with catastrophic hospital coverage.

OPTIONAL MEDICARE VOUCHER

Last year, Congress, with the support of the administration, amended the medicare statute to permit payments on a risk basis to HMO's and other competitive medical plans. This year we propose to expand this provision. The optional voucher provision would build on current law by allowing medicare beneficiaries to use medicare benefits to enroll in a wider array of private health plans. Medicare would contribute an amount equal to 95 percent of what it would have cost to care for the beneficiary if he or she had elected traditional medicare coverage. If a beneficiary selects a private health plan that costs more than medicare's contribution, the beneficiary must pay the difference. If the private plan costs less than medicare's contribution, the beneficiary would qualify for a cash rebate. Enrollment in a private health plan would be voluntary. Once a year beneficiaries would have the opportunity to switch private health plans or to elect traditional medicare coverage. A qualified health plan may be an HMO, an indemnity insurer, or a service benefit plan. At a minimum, all private plans must cover the services provided under parts A and B of medicare and must participate in a coordinated annual open enrollment period.

Cost-sharing for medicare-covered services may not exceed comparable out-of-pocket expenses under medicare, so no beneficiary could purchase coverage less extensive than that provided by medicare.

FREEZE MEDICARE PHYSICIAN REIMBURSEMENT FOR 1 YEAR

Medicare physician expenditures, the second largest component of medicare spending, have been increasing at highly inflationary rates. In 1982, they increased 21 percent and are expected to rise 19 percent in 1983. Because of these large increases and because physicians have been largely unaffected by the cost-control provisions of TEFRA and the Omnibus Budget Reconciliation Act of 1981, we propose to freeze medicare's physician reimbursement levels for 1984 at 1983 levels. Physicians, too, must share the burden of slowing the rise in health care costs.

INCREASE MEDICARE PART B PREMIUM IN STAGES

As part of our restructuring of the medicare financing system, we propose to modify the timing and rate of increase in the part B premium. The intent of this proposal is to move closer to the original balance premium and general revenue financing of part B, and to coordinate the timing of future premium increases with the date of annual social security payment increases.

When medicare was established, premiums covered half of the estimated costs of part B, with the remainder financed from general revenues. This balance has eroded over the years until in 1981, premiums contributed less than one-quarter of the costs. TEFRA provisions suspended the limitation on annual premium increases and set a new premium level at 25 percent of projected costs for each premium year. Under the social security amendments, this percentage requirement to be met by premiums will take effect in calendar year 1984 and run through 1985. At the same time, the current $12.20 premium will remain in effect through 1983 with enough general revenue added to make up any shortfall between premium contributions and estimated expenses.

Under our proposal, we would raise the part B premium in stages: Maintaining the current level of $12.20 per month from July 1, 1983 to the end of the year; increasing the premium to 25 percent of projected costs for calendar year 1984; and increasing the premium by equal increments of 2.5 percent beginning January 1, 1985 until it reaches 35 percent of projected costs in January 1988. After January 1, 1988, the premium for each calendar year would be set at 35 percent of estimated costs. The proposal includes a "hold-harmless" provision. Beneficiaries who have their premiums deducted from their social security checks (about 90 percent of the beneficiaries) will not have the dollar amount of those checks reduced below the previous year's level due to the premium increase.

INDEX PART B DEDUCTIBLE TO THE MEDICARE ECONOMIC INDEX

We also propose to index the part B deductible to the annual changes in the national medicare economic index. This provision would help maintain the constant dollar value of the deductible, thereby maintaining the value of the deductible as a deterrent to unnecessary utilization. Current law does not provide for regular increases in the deductible to reflect increases in health care costs. As a result, the initial beneficiary liability for medical services has decreased in real terms over time, shifting most of these costs to taxpayers in general.

In addition to these major medicare proposals, our legislative package includes several other proposals that would strengthen program management, improve incentives for efficiency, and produce savings in program spending. Included are proposals to institute competitive bidding for laboratory services and durable medical equipment, create consistent reimbursement policies for durable medical equipment, initiate an enhanced medicare contracting strategy, and delay entitlement to medicare benefits for the elderly for 1 month.

CONCLUSION

We believe these proposals to improve medicare reimbursement and financing represent complementary efforts to constrain health care costs. Not only are they based on working, marketplace incentives, but also they follow consistent and understandable principles:

They enhance cost awareness for all parties, consumers and providers alike.

They act to restore the incentives for cost-effective health care.

They improve the structure of medicare financing, reimbursement, and coverage, especially by providing catastrophic coverage.

They enhance the opportunity for choice among different health coverage plans; and

They stimulate competition in the health care sector.

These proposals, when coupled with the newly enacted recommendations, represent a strong beginning and will achieve short-term stability for the HI fund. Long-term resolution is an issue still before us. Additionally, I feel a strong responsibility as Administrator and guardian of the HI fund to continue to search for new and better opportunities to make the medicare program more efficient and effective, without compromising the availability of needed services to our beneficiaries. In this light we look forward to the recommendations yet to come from the Advisory Council on Social Security and to working with the Congress in seeking a resolution to this basis long-term financing problem.

I will be glad to answer the committee's questions at this time.

TABLE 1.—ESTIMATED OPERATIONS OF THE HI TRUST FUND ON THE BASIS OF 1983 TRUSTEES REPORT ALTERNATIVE II-B ASSUMPTIONS AND NATIONAL COMMISSION OF SOCIAL SECURITY REFORM PROPOSALS, CALENDAR YEARS 1983–92[1]

[Dollar amounts in millions]

	Income[2]	Outgo[3]	Net increase in funds	Funds at end of year	Ratio[4] (percent)
Calendar year:					
1983	$44,646	$41,128	$3,518	$11,682	20
1984	45,744	46,847	−1,103	10,579	25
1985	52,223	52,957	−734	9,845	20
1986	60,248	59,916	332	10,177	16
1987	65,291	67,450	−2,159	8,018	15
1988	70,093	75,093	−5,810	2,208	11
1989	74,851	85,449	−10,598	−8,390	3
1990	79,223	95,070	−15,847	−24,237	−9
1991	83,478	104,895	−21,417	−45,654	−23
1992	87,592	116,037	−28,445	−74,099	−39

[1] Includes starting trust fund balance updated by Treasury Department. Includes the lump-sum military transfer proposal for HI. Includes the prospective payments provision but does not include any fiscal year 1984 budget proposed law items. Excludes some minor provisions included in the Social Security Amendments of 1982 which were outside NCSSR proposals. These minor provisions have little effect on the fund balance.

[2] Includes an interest repayment for the interfund loan of $12,437 million to OASI. The interest amounts of $1,362 million in 1983 and $1,337 million in 1984 and later are theoretical. If these payments are not made, the fund at the end of the year would be $10,286, $7,677, $5,311, $3,887, and −$166 million in calendar years 1983, 1984, 1985, 1986, and 1987, respectively. Excludes repayment of loan principal.

[3] Savings attributable to prospective payment are computed as the additional savings which would be generated in fiscal year 1986 and later by eliminating the October 1985 sunset provision on the hospital rate-of-increase limits of section 101(b) of the Tax Equity and Fiscal Responsibility Act. The prospective payment legislation proposed by the administration does not mandate a system which would necessarily generate this level of savings. Instead, the level of the prospective payment rates is left to the discretion of the Secretary of HHS.

[4] Assets at beginning of year as a percentage of outgo during the year.

TABLE 2.—ESTIMATED OPERATIONS OF THE HI TRUST FUND ON THE BASIS OF 1983 TRUSTEES REPORT ALTERNATIVE II-B ASSUMPTIONS, NATIONAL COMMISSION ON SOCIAL SECURITY REFORM PROPOSALS, AND FISCAL YEAR 1984 BUDGET PROPOSED LAW ITEMS, CALENDAR YEARS 1983–92 [1]

[Dollar amounts in millions]

	Income	Outgo	Net increase in funds	Funds at end of year	Ratio (percent) [2]
Calendar year:					
1983	$44,648	$41,078	$3,570	$11,734	20
1984	45,959	45,544	415	12,149	26
1985	52,647	51,232	1,415	13,564	24
1986	60,923	57,970	2,953	16,517	23
1987	66,278	65,239	1,039	17,556	25
1988	71,473	73,400	−1,927	15,629	24
1989	76,688	82,547	−5,859	9,770	19
1990	81,410	91,735	−10,325	−555	11
1991	86,176	101,113	−14,937	−15,492	−1
1992	90,823	111,763	−20,940	−36,432	−14

[1] Includes starting trust fund balance updated by Treasury Department. Includes the lump-sum military transfer proposal for HI.

[2] Assets at beginning of year as a percentage of outgo during the year.

TABLE 3.—ESTIMATED OPERATIONS OF THE HI TRUST FUND ON THE BASIS OF 1983 TRUSTEES REPORT ALTERNATIVE III ASSUMPTIONS AND NATIONAL COMMISSION OF SOCIAL SECURITY REFORM PROPOSALS, CALENDAR YEARS 1983–92 [1]

[Dollar amounts in millions]

	Income [2]	Outgo [3]	Net increase in funds	Funds at end of year	Ratio (percent) [4]
Calendar year:					
1983	$44,470	$41,129	$3,341	$11,505	20
1984	44,956	47,033	−2,077	9,428	24
1985	50,897	53,824	−2,927	6,501	18
1986	58,751	62,168	−3,417	3,084	10
1987	63,446	71,304	−7,858	−4,774	4
1988	67,621	81,688	−14,067	−18,841	−6
1989	71,640	93,778	−22,138	−40,979	−20
1990	75,052	106,424	−31,372	−72,351	−39
1991	78,293	120,084	−41,791	−114,142	−60
1992	81,173	135,891	−54,718	−168,860	−84

[1] Includes starting trust fund balance updated by Treasury Department. Also includes the lump-sum military transfer proposal for HI, twice the tax rate for self-employed, and the prospective payments provisions but does not include any fiscal year 1984 budget proposed law items.

[2] Includes an interest repayment for the interfund loan of $12,437 million to OASI. The interest amounts of $1,362 million in 1983 and $1,337 million in 1984 and later are theoretical. If these payments are not made, the fund at the end of the year would be $10,109, $6,522, $1,945, and −$3,269 million in calendar years 1983, 1984, 1985, and 1986, respectively. Excludes repayment of loan principal.

[3] Savings attributable to prospective payment were computed as the additional savings which would be generated in fiscal year 1986 and later by eliminating the October 1985 sunset provision on the hospital rate-of-increase limits of section 101(b) of the Tax Equity and Fiscal Responsibility Act. The prospective payment legislation proposed by the administration does not mandate a system which would necessarily generate this level of savings. Instead, the level of prospective payment rates is left to the discretion of the Secretary of HHS.

[4] Assets at beginning of year as a percentage of outgo during the year.

TABLE 4.—ROUGH ESTIMATED OPERATIONS OF THE HI TRUST FUND ON THE BASIS OF 1983 TRUSTEES REPORT ALTERNATIVE III ASSUMPTIONS, NATIONAL COMMISSION ON SOCIAL SECURITY REFORM PROPOSALS, AND FISCAL YEAR 1984 BUDGET PROPOSED LAW ITEMS, CALENDAR YEARS 1983–92 [1]

[Dollar amounts in millions]

	Income [2]	Outgo [3]	Net increase in funds	Funds at end of year	Ratio (percent) [4]
Calendar year:					
1983	$44,468	$41,078	$3,390	$11,554	20
1984	45,130	45,874	−744	10,810	25
1985	51,314	52,354	−1,040	9,770	21
1986	59,403	60,701	−1,298	8,472	16
1987	64,360	69,812	−5,452	3,020	12
1988	68,861	80,158	−11,297	−8,277	4
1989	73,244	92,153	−18,909	−27,186	−9
1990	76,895	104,674	−27,779	−54,965	−26
1991	80,507	118,232	−37,725	−92,690	−46
1992	83,748	133,995	−50,247	−142,937	−69

[1] Includes starting trust fund balance updated by Treasury Department. Includes the lump-sum military transfer proposal for HI. Does not include the lump-sum uninsured transfers.

[2] Includes an interest repayment for the interfund loan of $12,437 million to OASI. The interest amounts of $1,362 million in 1983 and $1,337 million in 1984 and later are theoretical. If these payments are not made, the fund at the end of year would be $10,157, $7,903, $5,213, $2,118, −$5,294 million in calendar years 1983, 1984, 1985, 1986, and 1987, respectively. Excludes repayment of loan principal.

[3] Savings attributable to prospective payment were computed as the additional savings which would be generated in fiscal year 1986 and later by eliminating the October 1985 sunset provision on the hospital rate-of-increase limits of section 101b of the Tax Equity and Fiscal Responsibility Act. The prospective payment legislation proposed by the administration does not mandate a system which would necessarily generate this level of savings. Instead, the level of prospective payment rates is left to the discretion of the Secretary of HHS.

[4] Assets at beginning of year as a percentage of outgo during the year.

Chairman HEINZ. I want to yield to Senator Pressler who has some remarks and also for any questions he cares to ask.

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Well, Mr. Chairman, I hate to interrupt this, but let me say that I feel that this hearing is well timed, coming on the heels of the work in Congress on social security reform. As has been said today, in the estimation of many experts, the financing problems we will face with respect to medicare will be even more difficult to solve than those related to the retirement trust fund.

All of us were forced to make some difficult decisions during the social security debate, and it is difficult to imagine that we could have an area with potentially bigger deficits, but that is what we are talking about. So I think we are doing ourselves a favor by considering this problem now.

The financing problem results from a rate of inflation for medicare reimbursement costs that will exceed the increase in covered earnings. Without some changes in the system, the hospital insurance trust fund will be depleted by 1987, as has been well demonstrated here. As with the solutions proposed for the social security shortfall, the options presented to solve this problem are not pleasant prospects. Indeed, all of the options presented will mean sacrifice on the parts of some groups of Americans.

Increasing beneficiary coinsurance is a difficult thing to ask of the majority of older Americans who live on fixed incomes. An increase in payroll taxes, like general revenue financing, does not really solve the inflation problem. Prospective reimbursement may well affect the quality of or access to care.

Obviously, none of these constitutes an easy choice. There may be others that we have not yet considered, but none of them will be accepted easily, I am sure. We owe it to ourselves to begin to consider the options now, and I commend you, Mr. Chairman, for calling this hearing. I thank our distinguished witnesses and I look forward to the testimony.

Chairman HEINZ. Senator Pressler, I know that you have an 11 o'clock commitment. If you have any questions for Dr. Davis and the other people from HHS, we would be most willing if you want to proceed to any questions now.

Senator PRESSLER. Well, if we could go back to the chart on taxes on health insurance plans based on family income. Do you know what chart I am talking about?

Dr. DAVIS. Yes.

Senator PRESSLER. Now, this means that the annual tax on health insurance plans would vary according to family income, is that correct?

Dr. DAVIS. Yes; this means that if the individual opted to take an insurance plan that is over the $175 maximum, then there would be a tax on that. But the alternative is that they could shop for a less expensive plan. In general, many of the less expensive plans are less expensive because they do not cover first dollar coverage; they ask for some cost-sharing upfront.

The tax cap is a progressive cap, and that the higher the salary, the more the taxes are. At the moment, I think the problem is that the hospital insurance programs are not taxed as a part of income, and that the higher income level individuals are actually being subsidized more than the lower income levels, if they choose the plan.

Senator PRESSLER. I see, because of the tax structure.

Dr. DAVIS. Yes.

Chairman HEINZ. Doctor, just to follow up on Senator Pressler's question, this is essentially a snapshot of what would happen to the average taxpayer in those categories——

Dr. DAVIS [interrupting]. That is correct.

Chairman HEINZ [continuing]. Depending on the particular health insurance plan. An individual taxpayer, let us say, if they were earning $50,000 to $100,000, they might pay more than $133, or they might pay less. It would depend on the cost of that plan.

Dr. DAVIS. Yes, it would.

Chairman HEINZ. Now, this is from a CBO study dated May 1982, that is fairly current, so you are saying those numbers are still good for fiscal 1984?

Dr. DAVIS. Yes.

Chairman HEINZ. Do they take into account the Reagan tax cuts?

Dr. DAVIS. I beg your pardon?

Chairman HEINZ. Do they take into account the lowered marginal rates in Roth-Kemp?

Dr. DAVIS. I am not sure. We would have to provide that for the record.

Chairman HEINZ. All right.

[Subsequent to the hearing, Dr. Davis provided the following information:]

The figures in chart 12 take into account the Kemp-Roth tax reductions embodied in the Economic Recovery Tax Act of 1981.

Chairman HEINZ. Senator Pressler, excuse me for interrupting you.

Senator PRESSLER. I appreciate your efforts to reduce expenditures by introducing a greater element of competition into the system. I come from a very rural State, where our largest city has 50,000 people, and we are dimpled with small towns of 500 and 600, where we struggle with nursing homes and 40-bed hospitals, and so forth, which you are well aware of.

I am concerned for many of my constituents who have very few choices available to them. Has the situation of rural residents been taken into consideration in your plan?

Dr. DAVIS. Yes, it has. Actually, we are also concerned about the accessibility of care for all of our beneficiaries, including those in rural areas. I think one of the things that has happened over the years, however, is that there has been a significant improvement, both by the building of new facilities in the more rural areas and second, by the increase in the number of physicians. According to our projections, as the physician numbers increase over the next few years, physicians will move to the more rural areas in order to continue to practice.

Senator PRESSLER. The whole issue of sometimes having to relocate to get certain types of medical expenses makes it more expensive for a rural person. Some of our hospitals can give primary care, but not more complicated types of care that might be available in a bigger city, and sometimes the total cost ends up being more.

Mr. Chairman, I have to go and preside over the Senate, which is a much more august-sounding job than it is in actuality.

Chairman HEINZ. Senator Pressler, I will rest assured the Senate is in good hands, at least, starting at the hour of 11 o'clock.

Dr. DAVIS. Senator Pressler, one of the things we have in our hospital payment plan is a recognition of the rural areas. There certainly is a difference, and for the next few years, we will definitely be paying urban and rural hospitals differently.

Chairman HEINZ. Senator Pressler, thank you.

Senator PRESSLER. Thank you.

Chairman HEINZ. Dr. Davis, thank you for some very helpful and illuminating testimony. I know that the Health Care Financing Administration is under a lot of pressure, appropriately so, to find methods of reducing the cost to the taxpayers of the bills that we are currently paying. And indeed, I commend you on your work on the prospective payment provisions that are in legislation passed by the Congress about 2 weeks ago, which we hope are slowly winding their way to the desk of the President. I am sure you would like to see him sign them. I am sure that just as soon as those people, probably skilled in cryptography, decipher what it was we decided about 1:30 a.m., the Friday morning before we broke, the bill will be on down to the President's desk. We are hopeful that the prospective reimbursement provisions will be of use to you as a mechanism in constraining the runaway cost of health care.

Though you are generally focused on some of the more immediate, short-term problems, I think you probably share with us the concern over the long term, not just what happens sometime between now and 1990. You and CBO come out at more or less the same point. CBO thinks there is a "grim reaper" in our future in 1988; you are within a year or so of that. Let me ask you this: You say that the administration's fiscal 1984 medicare proposals would only delay the depletion of the HI fund for 1 year. That sounds about right.

What would the longer term impact of these proposals be on the 25-year deficit projections?

Dr. DAVIS. I think one of the clear indications is that it is difficult for us to project what change in behavior will be brought about. However, we are trying to design our entire incentive program, not just to change the reimbursement system and reduce the dollars that are flowing out, but also to change behavior. Our actuaries have had difficulty trying to measure the impact of such a behavioral change. So we really cannot accurately project what will occur in that outyear period of time.

It is our hope that it would gain us additional time, because, as I said earlier, I think that the most significant thing we have to do is to change everybody's behavior and change the way they think about the cost of health care. I do not believe we can measure how quickly that will occur. We believe that the kinds of incentives that we are developing as a total package—meaning the reforms in the reimbursement system, the reforms in terms of consumer financing mechanisms, and the additional consideration of alternative delivery systems, in other words, finding the most appropriate delivery system at the least cost—will yield us additional time.

Chairman HEINZ. I gather what you are saying is you just do not have confidence right now in your ability to project the long-term cost savings of these proposals?

Dr. DAVIS. I think we can project what the deficit is going to be, and we do know that we have to reduce the outlays or increase the taxes, but——

Chairman HEINZ. This, we all understand, but one of the things that made it possible for us to make some progress on social security and OASDI reforms that we implemented is that we were able to cost out—and I said this before you came, I think—with some degree of accuracy what various options would do. Would you be able to provide us, after some more careful consideration, with a better estimate of what these proposals, taken either singly or in aggregate, might do over 25 years?

Dr. DAVIS. We can certainly try. I think again, I go back to the fact that costing out behavior change is quite difficult to deal with, but we will make some attempt as we continue to look at these issues.

Chairman HEINZ. I understand that, but if you took the famous Blue Book that Bob Meyers and others provided us with, almost every single one of those proposals had some real behavioral predictions associated with it. For example, in raising the retirement age to 67 and having a different graduation of the amounts that one might claim for early retirement, one has to make some very specific behavioral assumptions. They are always judgmental, but no matter how imprecise science is, you have to take a stand and declare what your best judgment is. We always know that when we do that, we are always going to be wrong to some degree. I am not going to try and say, "My goodness, here it is, 5 years later, and Carolyne Davis was off by 15 percent. Shame on her." If you were only off by 15 percent, I suspect that would be a monumentally, fantastically good job. So we would like you to do your best in that regard.

Just to highlight some interests of mine in this area, and talking about your shortrun savings that you had on your first chart—could we go back to the first chart, with the $663 million saving in fiscal 1984? Now, if you did not eliminate the existing limits on covered hospital days, how much would your savings be on this proposal? In other words, if you did not have the catastrophic element in your proposal, what would the savings be?

Dr. SCHIEBER. I could give you an answer we would have to modify slightly. On a full-year incurred costs basis, that would be about a $653 million cost in providing unlimited hospital days. Now, what we are talking about with all these numbers are obviously on a cash basis and for three-quarters of a year.

Chairman HEINZ. So roughly, your cost of giving unlimited hospital days is roughly half the savings you would get from all the other proposals, then?

Dr. SCHIEBER. I think to make that comparable, Senator, you would have to take about 60 percent of that—say, about $360 million—I am converting from a different number to make it comparable to that number for you, but in that range.

Chairman HEINZ. You have got a budget effect for fiscal 1984. Just in rough numbers, if you did not eliminate the existing limits on covered hospital stays, would you roughly pick up $1 billion? Would you pick up more or less than $1 billion?

Dr. SCHIEBER. That would be about correct.

Chairman HEINZ. Around $1 billion?

Dr. DAVIS. Yes.

Chairman HEINZ. Now, of that $1 billion, how much of it would result from changes, presumably, decreases in utilization, and how much of it would result simply from higher cost sharing?

Dr. SCHIEBER. We have not incorporated any net savings due to utilization changes into these numbers.

Chairman HEINZ. So the assumption is, for the purposes of developing these numbers, this is just the result of cost sharing, and anything you have in addition to that, in the way of reduced utilization would be a plus. Is that correct?

Dr. SCHIEBER. That is correct, Senator. To be specific, the increased costs from this proposal are, as you pointed out, from the unlimited hospital days, from eliminating the current coinsurance on days 61 to 90 and lifetime reserve days, from limiting the deductible to 2 per year, and from lowering the SNF coinsurance to 5 percent from the current 12.5 percent; that would cost us money, and the savings obviously comes from the new coinsurance on the earlier days.

Chairman HEINZ. The reason that I stress this area of behavior—and by the way, we are talking about behavior, ultimately, not just of the beneficiary, but of the health care provider——

Dr. DAVIS [interrupting]. Very definitely.

Chairman Heinz [continuing]. That in her testimony, on page 3, Dr. Rivlin stated—and I will quote it because I think it is immensely helpful and significant, that:

> Hospital costs attributable to medicare beneficiaries—

This is over the 1982 through 1995 period—

> Are expected to grow at an average annual rate of 13.2 percent, of which growth in the number of beneficiaries and their increasing age explain only 2.2 percentage points. Slightly over half of the higher per capita expenditures is expected to come from rising prices that hospitals pay for labor and other inputs. The remainder is due to increased services * * * and higher rates of admissions to hospitals.

Having nothing to do with the number of beneficiaries or the average age of beneficiaries. Those are behavioral, and they account for fully half of the runaway costs we have in this program. And it seems to me that we are never going to be able to deal with the health care issue until we get down to dealing with the behavioral elements here in health care.

I assume you agree with that?

Dr. Davis. Yes, absolutely. That is clearly one of the reasons why we felt it would be important to have an early cost-sharing through the coinsurance, in order to increase, not just the beneficiaries' cost-consciousness, but also the providers' cost-consciousness.

Having been a nurse and worked within a hospital, I can assure you that when everything is paid for by someone else, there is much greater tendency to use those resources very liberally. I think that becoming more aware of what things cost will help us to decrease our overall outlays.

Chairman Heinz. From the standpoint of the Congress, we would, obviously, prefer to obtain the maximum amount of behavioral change at the lowest cost to the beneficiary as possible. That would be the best case, where we could get people to be wiser consumers, hospitals wiser providers of health care, and do it just through that amount that at the margin is necessary to create changes in behavior, as opposed to simply trying to put more costs, more of the cost, on the beneficiary.

One of the reasons I have difficulty coming to grips with what you propose is, in order to start making those judgments, one has to get into the question of how much that you are looking at is behavioral, and you are saying, in effect, "Well, we have not looked at that." And so much of what your testimony provides, as I understand it, indicates that you are really talking about forms of cost shifting. They have a budgetary impact, as I understand it, since you are not taking any behavioral changes into account here—this is all cost shifting to the beneficiary, to other kinds of health care payment mechanisms.

I do not wish to put you in a box, but that is what I deduct from your testimony.

Dr. Davis. What we believe is that there will definitely be a change in behavior, but we feel it will be difficult to estimate the magnitude of what that change will be.

Chairman Heinz. Let me ask you this: CBO is assuming that hospital costs, as I mentioned, will go up 13.2 percent per year after 1985. What are your projections assuming?

Dr. DAVIS. I think ours are in general agreement with them. However, our latest estimates make the assumption that they be, on the average, about 11.5 percent.

Chairman HEINZ. Slightly lower.

Dr. DAVIS. Just slightly lower. Now, that does, Senator, assume that we will have a very tight exceptions policy as we administer our new system, and that is sometimes difficult to do, considering the fact that we get a great deal of pressure on us from outside forces to make exceptions. But our 11.5 average assumes that we would have a very tight policy relative to exceptions to the new systems.

Chairman HEINZ. Now, you have under part B proposed a freeze in physician fees. In the prospective payment bill, Congress directed you, HHS, to report back to us with a plan for putting inpatient physician services under prospective payment by early 1985. Does the Department have any other suggestions for slowing down the rate of increase of part B physician costs, or plans to increase physician assignment to prevent physician reimbursement limits from just resulting in increased costs to beneficiaries?

Dr. DAVIS. The whole area of physician reimbursement is something that we have begun to study, and we will continue to do so; it is a very complicated system. With the hospital system, we worked about 1½ years to develop what I think is a very fine system. It was based on 10 years of research activity, and only had 7,000 providers to deal with. Now, when you are dealing with physicians, you are dealing with an enormously confusing and complicated current system, based upon a charge system of UCR, or usual, customary, and reasonable rates. In addition, you are dealing with some 400,000 providers. As we begin to examine the possibility of changes in the system, we have to consider balances between urban and rural, between specialties, and between primary care and the higher technology areas. What we really need to do is to develop more studies and a wider data base, then make some decisions to move forward in this area.

Chairman HEINZ. I well remember, and I indeed shared a good deal of enthusiasm for it, that the administration started out as a major advocate of competitive proposals to reform the entire health care system. Now, we all realize that we are dealing with just a piece of the health care system, medicare, and you proposed, in a sense, two things that have some competitive elements to them. One is the optional medicare voucher—although we do not have the details of your legislation, and details can be very critical to the way a proposal like that could work; have they been sent down as yet, the details of your medicare voucher?

Ms. FEINSTEIN. Yes, legislation is on the Hill.

Chairman HEINZ. Do you know when you sent them down?

Ms. FEINSTEIN. In with the President's message, I believe, in February.

Chairman HEINZ. The specific legislation?

Dr. DAVIS. Yes.

Chairman HEINZ. Thank you. We will find it.

The other proposal that you have introduced is the tax cap, which we have discussed a bit so far. What has happened to the other competitive proposals—the employee choice, the equal contributions for all employees, and so forth—the kinds of proposals that were in Senator Durenberger's proposal, the kinds of proposals that Congressmen Stockman and Gephardt used to champion? Where are those broader, systemwide reforms?

Ms. FEINSTEIN. I think a great deal of them are embodied in our voucher proposal, including an expansion of those providers who could qualify to give a voucher to a beneficiary and more competition in that the benefit package must be at least as comprehensive as medicare. However, if the provider can deliver that package more efficiently, the legislation speaks to the provision for returning to the beneficiary in the form of a rebate those savings, which is not permissible under current law, or to reduce cost sharing, or to offer additional benefits. We feel that is a tremendous expansion in the HMO package that is currently available to beneficiaries and ought to foster some competition.

In addition, our package contains a proposal for competitive purchasing of lab and durable medical equipment, and a proposal for competitive contracting for claims processing—an issue that gets very little attention, but that we think is very significant. We believe that having one line of our Federal budget, as large as it is, to continue to be reimbursed on a cost basis seems like something we ought to move away from very vigorously, and we hope this issue will receive some attention from the Congress.

Chairman HEINZ. I think those all have some promise associated with them. Certainly, bidding for lab services can dramatically reduce the costs.

But in terms of the systemwide reforms, it seems to me you have not quite gotten my question. You have been talking about things you plan to do with medicare, and medicare still is a minority of what we spend in this country on health care. The way things are going, we cannot guarantee that. But I am talking about systemwide reforms. You are not.

Ms. FEINSTEIN. I think the tax cap is a systemwide return. As the employed population is made more aware of the costs of health care, we believe it will serve as a method to expand HMO's and other more efficient delivery systems, which are not being spurred on in terms of choice because the beneficiary, in this case, the employees, of this country, have a tax subsidy, and the cost of health care is simply hidden from them.

So I think when you take the tax cap, together with some of the things in the medicare package only, you have begun marching down that road.

Chairman HEINZ. Well, there is some evidence to suggest that a tax cap by itself will not bring about the behavioral changes that you suggest.

When I served on the Health and Environment Subcommittee in the House between 1972 and the end of 1976, one of the things that we thought would bring about a tremendous change in the health care system was the dual choice provision for employers to offer for either HMO's or indemnity-type health care insurance. Frankly, the dual choice by itself did not provide much. I expect one element taken by itself will not provide much. If you provide dual choice without any incentive to shop, people will not shop. If you provide an incentive to shop, but no really available menu of choices, I suspect you are not going to have anybody shopping because they do not know where to look.

It seems to me that unless you integrate your proposal with other elements, you are going to raise some revenues, but I do not think you are really going to change the system much—or, would you strongly disagree?

Dr. DAVIS. I think one of the things that we recognize is that as we begin to encourage more developments in the area of HMO's and the preferred provider organizations—PPO's—that does stimulate interest within a particular geographic area for others to do likewise, either to join the same plans or to implement their own. We are definitely committed to do that. Last year, we awarded 26 medicare contracts and about six medicaid contracts to enhance competition through the utilization of HMO's or PPO's and in some cases, to move into primary care case management. We think that all of these are important to continue as demonstrations or research areas. As we do that, we not only demonstrate that alternatives such as HMO's or PPO's are effective providers of care, but we also stimulate interest from the private sector to move in this direction. And we are committed to doing similar demonstrations this year.

Chairman HEINZ. Let me share a concern with you—it may have occurred to you—that grows out of my experience dealing with a hot issue, social security, over the last 2 or 3 years.

The concerns are twofold. One, every time there was an attempt by the administration, in this case, to try and deal with the very real financial solvency problems of social security, they did so on some kind of a piecemeal basis—Secretary Schweiker, you will recall, in 1981, had a proposal; the Senate Budget Committee in 1982 came up with a proposal—we all, I think, remember with some vivid clarity what happened to those proposals. They were not integrated into a solution that dealt with the significant entirety of the problem. And it seems to me that the road to frustration, failure, and potential political holocaust is strewn with minefields when we deal with the problem piecemeal.

You opened yourselves up, anybody trying to do something in the area opens themselves up, to accusations that all you are doing is just trying to put more costs on the backs of senior citizens, and so forth. I refer you, chapter and verse, to the Congressional Record, both in the House and the Senate, immediately after any of those proposals were made.

So first, it seems to me that there is a political risk which, because there is a political risk, carries with it a significant failure risk in your achieving what you want to achieve. That is one concern I have.

Second, in dealing with the problem piecemeal, one opens oneself to being hit at a variety of different times by a variety of special interests. My constituents still remain somewhat amazed that we got any kind of social security legislation, because they say, "Well, the Federal employees were against it, and some of the small business people were against it, and some of the senior citizens' groups, like the AARP, were against it, and labor was against it, because you raised the retirement age." And the answer really was, in practical terms, because everybody was kind of sharing a moderate, but necessary, part of the sacrifice, we could say to each group, "This is a reasonable proposal." But in dealing with something piecemeal, you cannot say that. And if we want to come along and mandate choice, hypothetically, after, hypothetically, we have adopted the administration's tax cap, we cannot say to all those people who will oppose strongly mandated choice, "Look, we are making a systemwide improvement here."

How would you respond to those concerns, Dr. Davis?

Dr. DAVIS. I would respond by again indicating that I think we are trying to take a broad view and not a piecemeal view. What we are trying to do is to look at the whole system. As I indicated earlier, it seems like the health care system really has three components—the patient, the third-party payer, and the provider. We are trying to look broadly at making changes in behavior by enhancing cost-awareness in all of those sectors, and we are doing that by suggesting reform in the reimbursement system, and as we have already indicated, we have accomplished the first part of that with the reforms in the hospital payment system, and we will continue work in this area.

Chairman HEINZ. Just so we understand each other, yes, you have made some changes in reimbursement, for the medicare program only.

Dr. DAVIS. Yes.

Chairman HEINZ. You are talking about physician reimbursement changes for the medicare program only. That is a very small part—less than 25 percent—of the entire health care expenditures. And you have received testimony—you have even expressed concern, if my memory serves me, about cost-shifting as a result of what we are doing in prospective reimbursement. That is helpful to the Federal Government in the short run, but it does not get at the underlying problem in the long run—indeed, it may make other people's problems worse—isn't that correct?

Dr. DAVIS. Well, we would hope as we move into the prospective payment that it will change behavior in the hospitals and hopefully, would not make other people's problems worse, because since we are going to pay for an outcome, and that is an easily tracked outcome by each DRG, I believe that if there is going to be cost-sharing that the other third-party payers could very easily add their costs and go back and say, "Why would you be charging us additional, because we know that the Government now, as a prudent buyer, is paying for it under this system."

Chairman HEINZ. Well, the answer is, even before you came to Washington, D.C., and before the Reagan administration took office, that is exactly what is happening now. If you analyze what the charge per unit of service is to the Federal Government, we get a bargain rate that is below the average cost of service that the hospital incurs in those areas that have been studied. But this is because we have, if you will, buying power—buying power—that we get something that is not a cost-based rate reduction for medicare beneficiaries. It is not a cost-based rate. It goes beyond that, with the result that there has been, over many years, a tremendous amount of cost-shifting from the medicare program to other insurance programs. That is a well-established fact.

I gather there is no dispute about that.

Dr. Davis. Well, I think from time to time, we dispute with the provider community relative to what we think is appropriate for us to pay.

Chairman Heinz. I do not doubt that.

Dr. Davis. Clearly, the statute does clarify those things.

Chairman Heinz. We would hope you never stop.

Dr. Davis. We simply do not pay for some of the items that the provider community believes should be in there, and to the degree that they make additional charges based on those costs, we do not recognize those, that is true.

I understand your concern relative to the larger picture of what are we doing to change behavior within the entire health care system. In terms of the medicare and medicaid programs, I think it is incumbent upon us to get our house in order, in order to demonstrate more effectively what changes need to be made within the entire system, and that is really where we have been spending our attention these last 2 years. We have been trying to develop our own systems so that we can say that we have our house in order, too. As I indicated earlier, the tax cap certainly is the beginning of looking at the major problem nationally.

Chairman Heinz. Dr. Davis, I have one last question for you. It is my understanding that medicare beneficiaries currently pay about 29 percent, or about $1,000 per year, of their medical expenses out of pocket on average. Is that correct, roughly?

Dr. Davis. That is roughly correct, yes.

Chairman Heinz. How much will the administration's 1984 budget proposals increase beneficiary cost-sharing for an average medicare beneficiary who has one average, 10- to 11-day hospital stay per year?

Dr. Davis. It would be roughly about $280 additional cost in a year.

Chairman Heinz. Dr. Davis, I want to thank you for being here. Clearly, we are only beginning to scratch the surface of this issue. We have many difficult choices ahead of us. I hope that we can find, institutionally, a way of getting Congress to work not only with you, but the entire health care industry, in dealing with these problems. I intend to explore, starting today, the formation of a task force, not a high level commission, but a task force, that would work under the auspices of both the House and Senate Aging Committees, the House Ways and Means Committee and its Health Subcommittee, and the Senate Finance Committee and Senator Durenberger's Health Committee, because, clearly, as evidenced by the testimony we have received from you and Dr. Rivlin to date, there is a good deal more of work that has to be done, and indeed, it involves identifying some of the critical variables and learning how to measure them.

And we had best start that at the earliest possible date. We, of course, would welcome administration help—indeed, we will absolutely need administration help—if any such idea, assuming the one I mentioned is worth it, in order to have any chance of success.

Dr. Davis. Clearly, I think it is important for us all to work together on this problem. It is a large problem, but we are all, I am sure, committed to guaranteeing that these programs are available as they need to be for the medicare beneficiary. We do have a few years' time, and I think it is important for us to use all the intellectual wisdom that we can garner to focus on this particular problem.

Chairman HEINZ. Dr. Davis, thank you very much.

Dr. DAVIS. You are welcome.

Chairman HEINZ. Our next witnesses are a panel—Dr. Joseph Newhouse, Dr. Gail Wilensky, and Dr. Karen Davis.

Dr. Newhouse, would you please proceed? We have some lights down there for the witnesses to insure that they do not go past 10 minutes. We hope that you can beat the light, but please, do not exceed it.

STATEMENT OF DR. JOSEPH P. NEWHOUSE, SANTA MONICA, CALIF., HEAD, ECONOMICS DEPARTMENT, THE RAND CORP.

Dr. NEWHOUSE. Thank you, Senator Heinz, very much.

I am pleased to be here today. I want to report on the initial results of an experiment that my colleagues and I have conducted to study the effects of cost-sharing in health insurance.

The Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services has supported this work—including Dr. Davis, when she was in that office.

Chairman HEINZ. Indeed, we all want to welcome Dr. Davis back a little closer to home. She is not that far away at Johns Hopkins.

Thank you, Dr. Newhouse. Please proceed.

Dr. NEWHOUSE. It is gratifying to all of us who have worked on the project to be able to report some returns from the investment that has been made in it. But the conclusions that I draw from the research results to date, as well as the additional comments, are my personal views, and they do not necessarily reflect those of the Rand Corp. or its research sponsors.

The experiment enrolled 7,706 individuals in 2,756 families in 6 different places in the United States—Seattle, Wash.; Dayton, Ohio; Charleston, S.C.; Fitchburg, Mass.; Franklin County, Mass.; and Georgetown County, S.C. Of these families, 70 percent participated for 3 years and the remainder for 5 years.

The families were randomly assigned to alternative health insurance plans that varied the amount of cost-sharing. About 30 percent of the families received all medical services free; there was no cost-sharing. The remaining families had to pay 25, 50, or 95 percent of their medical bills, but all the plans had a catastrophic ceiling. The families could not be out of pocket more than $1,000 in a year. For the poor, this $1,000 ceiling was scaled down. Specifically, the ceiling was either 5, 10, or 15 percent of family income, or $1,000, whichever was less. In the results described in the tables in my statement, the families with different ceilings are grouped together, and I have distinguished them only by the coinsurance rate.

One of the plans applied cost-sharing only to outpatient services. Inpatient services were free. This plan resembled a plan with a $150-per-person deductible, and I will refer to it as the individual deductible plan. We included it to test the hypothesis that failure to fully cover office visits and other outpatient expenditures had the perverse effect of increasing expenditure, as individuals either delayed seeking care or as physicians hospitalized them to treat conditions that could have been mandated on an outpatient basis.

The results from the first 40 percent of the data, which come from four of the six sites, are now in, and I have displayed them in table 1 in my statement [see page 62]. They show that expenditure definitely responds to cost-sharing.

The expenditure in the least generous plan, which is called the family deductible plan in the table—that is 95 percent coinsurance up to $1,000 maximum—is about one-third less than when all care is free. These, by the way, are about mid-1977 dollars. The $400 figure for free care would be closer to $650 today.

The plan that had cost-sharing for outpatient services only, the individual deductible plan, also showed lower expenditures than did the plan with free care. The cost-sharing did not seem to have the perverse effect of raising expenditures.

This reduction in expenditure was similar across income groups. I show in table 2 the reduction for the lowest third of the income group in each of the four sites and the highest third of the income distribution, and as you can see, those are about the same [see page 62]. But you should remember that the ceiling on out-of-pocket expense was income related, and the poor were more likely to exceed it. And we can infer that there would have been a greater reduction in use among the poor if cost-sharing had not been income related.

Use also fell; the likelihood of both a visit and hospital admission fell as the coinsurance went up, as table 3 shows [see page 63]. I did not include a table, but once admitted to the hospital, we could not detect any effect on expense per case across the plan. That was probably because 70 percent of the people hospitalized exceeded the $1,000 ceiling and had all additional services at no charge to them.

What bearing do these results have on proposals to alter the medicare program? Unfortunately for our purposes today, the experiment included no medicare eligibles. Hence, a purist might assert that the results can shed no light on proposals that apply to medicare. I think, however, that most people would probably find such a position unreasonable; although the utilization response among the elderly, if they had been included, could have been somewhat different, I personally doubt that it would have been vastly different. I want to assume that a roughly similar response would have been observed among the elderly and ask what we should make of all this.

Those favoring more reliance on cost sharing have traditionally argued that it makes individuals and their physicians more prudent buyers of care. In particular, they argue that cost sharing lessens the likelihood that expensive medical resources will be used to treat trivial problems.

The experimental results do indicate that individuals are cost conscious, and that they can markedly reduce the use of care. But that, of course, is not the end of the issue. There are several objections that one hears to greater use of cost sharing. One of the most important relates to who pays, and it has come up already today, several times. More cost sharing obviously does more than reduce demand; it shifts costs to users. In figure 1, I show an illustration of the cost shift [see page 64]. This particular cost shift comes from increasing the deductible from about $100 per person per year to

$2,000 per person per year; by my estimates, demand will fall by a factor of about one-third if one does that—that is the slanting lines—but the payout by the insurer falls by a factor of 5, the difference being accounted for by the shift of cost to the users. If the insurer is the Government, as in the case of medicare, that is strong tonic for the trust fund. It will lessen the burden on the labor force at the expense of increasing the burden upon those whom the program was designed to aid. Whether that shift is desirable is a political question of the first order.

The second most important objection to cost sharing is that it may damage people's health by deterring them from seeking necessary care. The experiment is designed to address this question, but unfortunately, those results are not yet in. In the argot of the television networks on election night, "More precincts must report for us to make a prediction." So we do not really know yet if the one-third decrease in use affected the participants' health status, but we intend to answer that question, I hope, later this year.

Whether our findings, however, among the nonelderly would apply to the elderly with their different mix of disease is open to debate.

A third objection to cost sharing is it can leave families whom illness strikes financially devastated. This could happen if there were no ceiling on out-of-pocket expense, but in the experiment, there was such a ceiling, and the administration is proposing a ceiling for part A of the medicare program. I personally welcome that proposal and consider it long overdue. Indeed, I would have personally preferred an analogous proposal for part B. The cost of such a ceiling must, of course, be financed. More initial cost sharing is one reasonable method to do so. In effect, it shifts the premiums paid by the nonelderly toward financial risks that are more serious and leaves the costs that the elderly must then finance themselves to the first-dollar expenditures that household budgets can more readily bear. But exactly how much of the first-dollar expenditure the elderly themselves should finance and whether those charges should be related to income are questions that Congress must decide.

But even if those ceilings were added, there would be an important financial risk on long-term care for the elderly, and it is likely to become steadily more prominent. I think financing long-term care is standing right in line behind the trust fund deficit we have been talking about today on the future agenda of problems.

But the issue today is initial cost sharing for acute medical care services. Whatever its other merits or demerits, I doubt that more initial cost sharing is going to have much effect on the steadily rising trend of hospital costs, and that is because I think the last dollar is going to continue to be insured. I think in short that more cost sharing will mean that costs will be lower at each point in time, but the trend will continue on up.

The notion here is that the last dollar coverage is likely to stay in place, and even if many of the things we have been talking about are enacted, such as the tax cap, the last dollar coverage is likely to stay in place. I think people are going to want that coverage to be insured against the risk of hospitalization, and once the coverage is in place, we could anticipate that costs would continue to increase.

I have some comments on regulation, as well. In brief, I think that regulation is not going to come without a sacrifice in benefits.

I see the red light——

Chairman HEINZ. Finish your sentences, please.

Dr. NEWHOUSE. In sum, I do not put forward a recommendation among the three various ways of proceeding. Those judgments must, obviously, be yours, and I am painfully aware that if there is little outright waste, which I suspect is the case, that those judgments are very difficult, and I do not envy your job.

Chairman HEINZ. Thank you, Dr. Newhouse.

[The prepared statement of Dr. Newhouse follows:]

PREPARED STATEMENT OF DR. JOSEPH P. NEWHOUSE

Thank you very much for inviting me here today. I wish to report on the initial results of an experiment that my colleagues and I have conducted to study the effects of cost-sharing in health insurance. The Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services has supported this work, and it is gratifying to all of us who have worked on the project to be able to report some returns from this investment. Nonetheless, the conclusions I draw from the work, as well as my additional comments, are my personal views and do not necessarily reflect those of the Rand Corp. or the sponsors of its research.

The experiment enrolled 7,706 individuals in 2,756 families in six different places in the United States. The families came from Seattle, Wash.; Dayton, Ohio; Charleston, S.C.; Fitchburg, Mass.; Franklin County, Mass.; and Georgetown County, S.C. Of these families, 70 percent participated for 3 years and the remainder for 5 years.

These families were randomly assigned to alternative health insurance plans that varied the amount of cost-sharing. About 30 percent of the families received all medical services free, there was no cost-sharing. The remaining families had to pay 25, 50, or 95 percent of their medical bills.

All the plans had a catastrophic ceiling; families could not be out of pocket more than $1,000 in a year. For the poor this $1,000 ceiling was scaled down. Specifically, the families were randomly assigned to plans that limited their out-of-pocket liability to 5, 10, or 15 percent of their income, or $1,000 whichever was less. In the results described below, the families with different ceilings are grouped together; the plans are distinguished only by the fraction of the bill the family had to pay (the coinsurance rate).

One of the plans applied the cost-sharing only to outpatient services; inpatient services were free. This plan resembled a plan with a $150 per person deductible; I will refer to it as the individual deductible plan. It was included to test the hypothesis that failure to fully cover office visits and other outpatient expenditures had the perverse effect of increasing expenditure, as individuals either delayed seeking care or as physicians hospitalized them to treat conditions that could have been managed on an outpatient basis.

The results from the first 40 percent of the data, which come from four of the six sites, are now in (see table 1). They show that expenditure definitely responds to cost-sharing; expenditure in the least generous plan (the plan with the 95 percent coinsurance up to a $1,000 maximum, which is called family deductible in the table) is about one-third less than when all care is free. Interestingly, the plan with cost-sharing for outpatient services only, the individual deductible plan, showed lower expenditures than did the plan with free care; cost-sharing only for outpatient services did not have the perverse effect of raising expenditures.

TABLE 1.—ACTUAL ANNUAL TOTAL AND AMBULATORY EXPENDITURE PER PERSON, BY PLAN: 9 SITE-YEARS

Plan	Total expenditure	Ambulatory expenditure	Number of person-years for total expenditure	Number of person-years for ambulatory expenditure[1]
Free care	$401 (±52)	$186 (±9)	2,825	2,834
25-percent coinsurance	346 (±58)	149 (±10)	1,787	1,792
50-percent coinsurance	328 (±149)	120 (±12)	766	766
Family deductible, 95-percent coinsurance	254 (±37)	114 (±10)	1,763	1,764
Individual deductible, 95-percent coinsurance[2]	333 (±74)	140 (±11)	1,605	1,609

[1] The sample for ambulatory expenditure includes 19 individuals with a known hospital admission for whom the amount of inpatient expenditure is missing.

[2] Coinsurance in this plan applies to outpatient care only; inpatient care is free.

Note.—95-percent confidence intervals are shown in parentheses. Dollars are current dollars, beginning in late 1974 and extending through late 1978. The figures are uncorrected for site price-level differences or for small differences in allocation to plan by site. Confidence intervals are uncorrected for intertemporal and intrafamily correlation; such a correction cannot be made without imposing strong assumptions about the nature of the correlation. Ignoring intertemporal and intrafamily correlation, the F-value to test the null hypothesis of no differences among the plans in total expenditure with 4,8741 degrees of freedom is 3.14, significant at the 5-percent level. The F-value to test the null hyothesis of no differences among the plans in ambulatory expenditure is 33.4, significant at well under the 1-percent level.

Source: J. P. Newhouse et al., "Some Interim Results From a Controlled Trial in Health Insurance," Santa Monica, the Rand Corp., Publ. No. R-2847-HHS, 1982.

The percentage reduction in expenditure was similar across income groups; table 2 compares the percentage reductions between the lowest third and the highest third of the income distribution in four of the sites. The poor show a bit greater reduction in expenditure in Dayton, but the other three sites show almost identical results. Because the ceiling on out-of-pocket expense was income-related, however, the poor were more likely to exceed it. We can infer that there would be a greater reduction in use among the poor if the cost-sharing were not income-related.

TABLE 2.—PREDICTED EXPENDITURE, BY INCOME TERTILE AND PLAN: YEAR 1

[Dollars for free plan; percentage of free plan elsewhere]

Plan	Dayton		Seattle		Fitchburg		Franklin County	
	Low	High	Low	High	Low	High	Low	High
Free care	$395 (±67)	$446 (±69)	$384 (±59)	$381 (±57)	$403 (±73)	$367 (±65)	$391 (±69)	$368 (±64)
25-percent coinsurance (percent)	71	78	*85	*85	†89	†90	*82	*83
50-percent coinsurance (percent)	60	67			71	71	*77	*78
95-percent coinsurance (percent)	65	72	72	73	75	76	65	67
Individual deductible, 95-percent coinsurance (percent)[1]	73	78	*86	*86	*81	*82	81	*82

[1] Coinsurance applies to outpatient care only; inpatient care is free.

Note:—95-percent confidence intervals are shown in parentheses. Comparisons do not hold factors constant other than income; they simply compare predictions for actual families with incomes below $9,548 and above $15,264 (1972 dollars) in Dayton; below $8,222 and above $13,882 (1973 dollars) in Seattle; below $8,884 and above $13,033 (1973 dollars) in Fitchburg; and below $9,374 and above $13,155 (1973 dollars) in Franklin County. These values define the lower third and upper third of the income distribution for the site. If no symbol appears to the left of the number, the difference from the free plan is significant at the 1-percent level. An asterisk (*) indicates that the difference is significant at the 5-percent level; a dagger (†) indicates that the difference is not significant at the 5-percent level. All tests are one-tail tests. Standard errors are corrected for intrafamily correlations.

Source: J. P. Newhouse et al., "Some Interim Results From a Controlled Trial in Health Insurance," Santa Monica, the Rand Corp., Publ. No. R-2847-HHS, 1982.

The likelihood of both a visit and a hospital admission fell as the cost-sharing increased (see table 3). Once admitted to the hospital, however, expense per case did not vary among the plans. This was probably because 70 percent of those hospitalized exceeded the ceiling on out-of-pocket expenditure and therefore received all additional services at no charge.

TABLE 3.—ANNUAL PROBABILITY OF ONE OR MORE PHYSICIAN VISITS OR HOSPITAL ADMISSIONS: 9 SITE-YEARS

Plan	Physician visits	Hospital admissions
Free care	0.84 (±.02)	0.102 (±.013)
25-percent coinsurance	.78 (±.03)	.081 (±.014)
50-percent coinsurance	.75 (±.05)	.072 (±.021)
95-percent coinsurance	.69 (±.04)	.076 (±.014)
Individual deductible, 95-percent coinsurance [1]	.73 (±.04)	.090 (±.016)

[1] This plan has zero coinsurance (free care) for inpatient services.

Note.—95-percent confidence intervals are shown in parentheses. The differences in the likelihood of a physician visit between the free plan and the other plans are significant at well under the 1-percent level; the differences in hospital admissions between the free care plan and the other plans are also significant at the 1-percent level, except for the free-care 25-percent coinsurance difference, which is significant at the 5-percent level, and the free-care individual-deductible difference, which is not significant at the 5-percent level. All tests are one-tail tests. Standard errors are corrected for intrafamily and intertemporal correlations.

Source: J. P. Newhouse et al., "Some Interim Results From a Controlled Trial in Health Insurance," Santa Monica, the Rand Corp., Publ. No. R-2847-HHS, 1982.

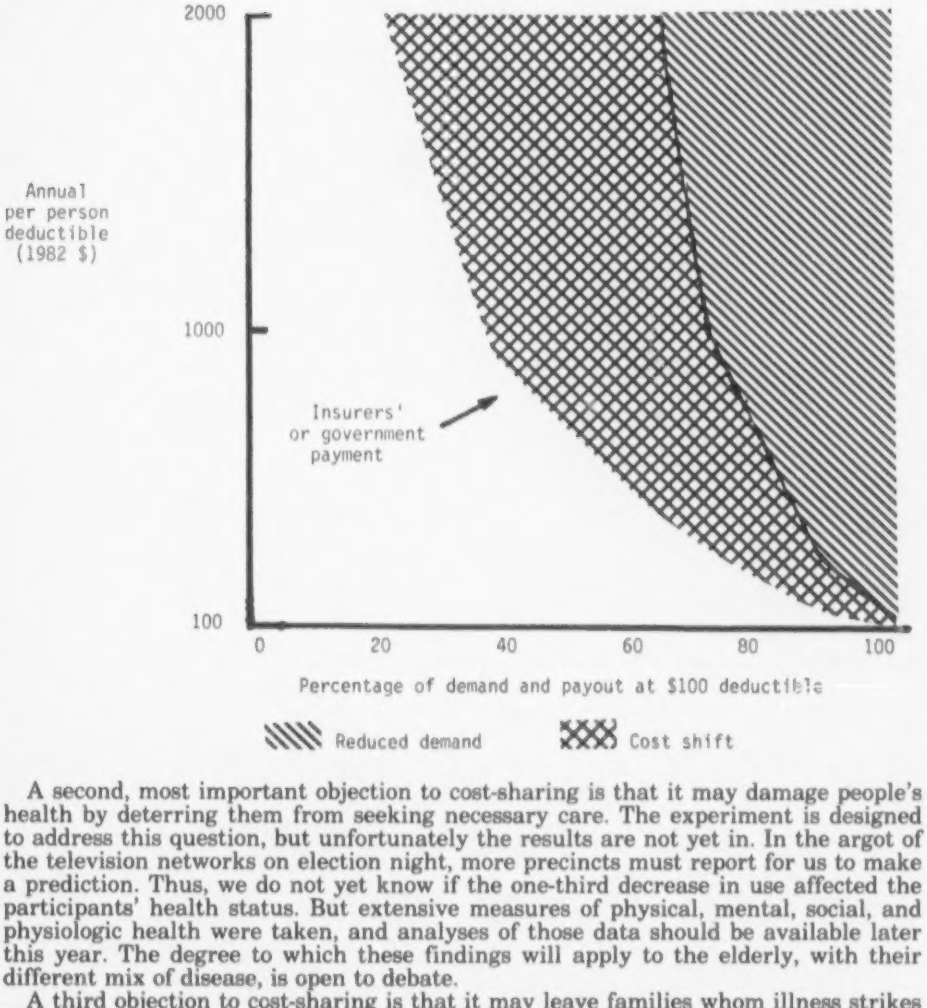
What bearing do these results have on proposals to alter the medicare program? Unfortunately for our purposes today, the experiment included no medicare eligibles. Hence, a purist might assert that the results can shed no light on proposals that apply to the medicare program. I think most people, however, would find such a position unreasonable. Although the utilization response among the elderly, had they been included, might have been somewhat different, I personally doubt that it would have been vastly different. Assuming that a roughly similar response would have been observed among the elderly, what should we make of these results?

Those favoring greater reliance on cost-sharing have traditionally argued that it makes individuals and their physicians more prudent buyers of care. In particular, they argue that cost-sharing lessens the likelihood that expensive medical resources will be used to treat trivial problems. The experimental results certainly demonstrate that individuals are cost-conscious and can markedly reduce the use of care. But of course this is not the end of the issue.

One hears several different objections to greater use of cost-sharing. One of the most important relates to who pays. More cost-sharing in part A of medicare clearly does more than reduce demand; it also shifts costs from payroll taxes paid by the nonelderly to those elderly who are sufficiently sick to require hospitalization. Figure 1 illustrates this shift from taxpayer to user. It shows the effect of increasing a deductible from $100 per person per year to $2,000 per person per year. Demand falls by about one-third, but the payout by the insurer falls by a factor of 5. If the insurer is the Government, as in the case of the medicare program, the shift in costs is a strong tonic for deficits in the medicare trust fund. It lessens the burden on the labor force at the expense of increasing the burden upon those whom the program was designed to aid. Whether this shift of burden is desirable is a political question of the first order.

Figure 1.

EFFECT OF VARYING DEDUCTIBLE ON INSURER (GOVERNMENT) PAYOUT



A second, most important objection to cost-sharing is that it may damage people's health by deterring them from seeking necessary care. The experiment is designed to address this question, but unfortunately the results are not yet in. In the argot of the television networks on election night, more precincts must report for us to make a prediction. Thus, we do not yet know if the one-third decrease in use affected the participants' health status. But extensive measures of physical, mental, social, and physiologic health were taken, and analyses of those data should be available later this year. The degree to which these findings will apply to the elderly, with their different mix of disease, is open to debate.

A third objection to cost-sharing is that it may leave families whom illness strikes financially devastated. This could happen if there were no ceiling on out-of-pocket expense. In the experiment, however, there was such a ceiling. The administration is proposing such a ceiling for part A of the medicare program. I personally welcome such a proposal and consider it long overdue; indeed, I would have preferred an analogous proposal for part B. The costs of such a ceiling must, of course, be financed; more initial cost-sharing is one reasonable method for doing so; in effect, it shifts the premium paid by the nonelderly toward financial risks that are more serious, and leaves the costs that the elderly must finance themselves to those "first dollar" expenditures that household budgets can more readily bear. Exactly how much of the first dollar expenditure the elderly themselves should finance, and whether those charges should be related to income, are questions the Congress must decide.

But even if out-of-pocket ceilings were added to the medicare program, an important financial risk would remain. Because medicare does not pay for chronic long-term care, an elderly person would still face the possibility of a large financial liability if she (or he) could no longer care for herself. In fact, long-term care expenditures are growing percentagewise faster than any other health expenditure. Because of the increased number of elderly, especially the frail elderly, the issue of financing long-term care is likely to become steadily more prominent.

But the issue before us today is initial cost-sharing for acute medical services. Whatever its other merits or demerits, more initial cost-sharing probably will not have much effect on the steadily rising trend of hospital costs. We do not want cost-sharing to apply very much to the last dollars of very large bills, precisely because we want insurance against financial devastation. But insurance of the last dollar—and I include both public and private insurance—sends a signal to those who are developing new medical procedures and equipment that anything with positive benefits for health will be demanded; it really matters little how much it costs. (The proposed ceilings on part A cost-sharing, by the way, would add negligibly to this problem; most hospitalized patients, and almost all medicare eligible hospitalized patients, already have their last dollar covered.)

Some of the new procedures and equipment, of course, we very much want. But some others may not be worth the cost. If, in fact, all the new developments were worth the cost, we probably would not be agonizing so much over the trend in health costs. The problem, of course, is how to distinguish that technology and those procedures that we want from that we do not find worth the price and even more, to whom the technology, once available, should be applied.

How does one know that new technology (including new medical procedures) is an important force behind the rapid increase in hospital expenditure? One sign is that cost per day accounts for most of the increase in hospital costs; admission rates and length of stay are comparatively little changed. Indeed, increasing hospital costs per day accounts for around half the increase in overall health care costs in the last two decades. This is not price inflation in the classic sense, because the product has changed; what can be done for people during a hospital stay is vastly different from what it was two or three decades ago.

If more initial cost-sharing is not likely to bend the trend in hospital cost per day down, what are the alternatives for dealing with the impending deficits in the medicare trust fund? One obvious alternative is to accept the upward trend and steadily increase revenues from either payroll taxes, general revenues, premiums, or more initial cost-sharing. Those supporting this view—a seemingly shrinking group—implicitly assume that the great bulk of the hospitals' increased capabilities is worth the cost; the Congress must then decide how to allocate the burden among the working-age population through taxes, the healthy or relatively healthy elderly through premiums, and the sick elderly through cost-sharing. Alternatively, one might argue that the alternatives could introduce important new problems that are even worse.

One of those alternatives is to increase price competition in medicine. The idea would be to let the market determine the rapidity with which new technology comes onstream. Much could be and has been said on the subject, and I do not propose to add much here. I would point out, however, that it will not be easy to increase competition in a manner that reflects the trend in hospital costs—even if consumers do not want to pay for those costs. For example, one of the procompetitive proposals, capping the amount of employer-paid health insurance premiums that can be excluded from taxable income, will probably leave the existing last-dollar coverage in place. Indeed, such coverage could remain mostly in place even if the entire premium were taxable, because the great majority of people probably want protection against large bills. Thus, the tax cap proposal, however desirable on other grounds, does not promise to much affect the trend in hospital cost per day anytime soon.

Another frequently heard alternative is some sort of regulation or legislation to "contain" hospital costs. If such containment were applied only to the medicare program (such as tighter limits on what medicare may reimburse hospitals), and if it were effective, I think the net result would be a tendency to segregate medicare beneficiaries in hospitals that have fewer resources. Hospitals that serve a large medicare population would find themselves receiving lower revenues than other hospitals with relatively few elderly, and the latter hospitals would be able to add new staff and equipment over time in a manner that should permit them to become more attractive hospitals. The nonelderly would tend to use these hospitals. Thus, I think this approach would place the burden of medicare cost-containment on the sick elderly.

Cost-containment regulation could be applied to the entire population, of course, rather than be limited to the medicare population. In that case the medicare population probably would not be segregated. In that case the medicare population probably would not be segregated. As with competition, many things have been said about this proposal, and I do not propose to add much to this subject either. But I would like to point out that this approach is not likely to be costless, and I do not have in mind the salaries of the regulators and the attorneys that represent potential litigants, although they too are costs.

Some who advocate hospital cost-containment appear to believe that there is a great deal of waste or "fat" in the hospital system, and that if we limited hospital revenues through legislation, we would really give up very little of value. This view assumes not only the existence of substantial waste, but also that a legislated ceiling would have the effect of cutting mostly waste rather than services offering real benefit. Both assumptions are problematical.

We may gain some perspective by looking beyond our shores. In the United Kingdom health care budgets are much more constrained than is being contemplated here. Nonetheless, the rate of dialysis for kidney failure among people under 45 is approximately the same as it is in the United States. But among people over 65, the rate is only about 10 percent of that in the United States. One can only conclude that in the United Kingdom cost-containment does not come without a sacrifice, in this case among the elderly with kidney failure. If sufficiently stringent cost-containment were applied to our end stage renal program, similar results could well obtain here, as indeed they did prior to the renal program's existence. One may argue that the benefits foregone from a revenue ceiling are not worth the costs, but we are very probably deluding ourselves if we think a revenue ceiling will only trim waste.

Thus, we can choose among variants of three alternatives. We can accept the cost increases, in which case the principal issue is who finances those costs. We can try to increase competition, but any change in the trend of hospital costs from increased competition is not likely to come quickly. Or we can attempt to regulate hospital revenues, in which case a principal issue is who does not receive treatment who otherwise would have received it, or who is treated differently than he or she otherwise would have been treated.

I do not put forward a recommendation among these various ways of proceeding; those judgments must be yours. And I am painfully aware that if there is little outright waste, those judgments are all the more difficult. I do not envy your job.

Chairman HEINZ. Next, we will hear from Dr. Wilensky, from the National Center for Health Services Research.

STATEMENT OF DR. GAIL R. WILENSKY, ROCKVILLE, MD., SENIOR RESEARCH MANAGER, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Dr. WILENSKY. Thank you, Senator, for the opportunity to appear before you today. I am here as a researcher, and although I work for the National Center for Health Services Research, and thus, for the Department of Health and Human Services, I do not speak for the Department, and my remarks should be not interpreted as such.

I will be presenting information based on a paper prepared by myself and Marc Berk, which I would like to have submitted for the record.

Chairman HEINZ. Without objection.[1]

Dr. WILENSKY. There is a general consensus that there has been an improvement in the health care of the elderly since enactment of medicare. This is seen both in terms of the numbers who are seeing physicians and also in terms of the decline in mortality among the aged, although since this mortality decline began prior to the advent of medicare, it is difficult to determine how much of the decline is due exactly to medicare and how much to other factors which affect longevity. It is clear, however, that the medicare program has had a dramatic effect on the manner in which medical care for the poor is used and paid for, and this is particularly evident for the poor and near-poor elderly, who are more likely to be dependent upon Government health programs.

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[1] See page 69.

In the analysis I am going to present today, I would like to focus specifically on the role of public insurance programs for the elderly whose income is below 125 percent of the poverty line—that is, the poor and near-poor population. In doing this, I have categorized the elderly poor into three groups—those who only have medicare, approximately 1.4 million individuals; a second group, who also have medicaid, in 1977, about 1.5 million individuals, and then a third group, about 3 million, who have either private insurance or CHAMPUS in addition to their medicare.

Now, while I am going to focus on the elderly poor, I would just like to point out that there are some substantial differences in the supplementation to medicare across income groups. Overall, about 66 percent of the elderly supplement their medicare with private insurance. However, this percentage varies quite sharply across incomes, with only 47 percent of the poor/near-poor having private insurance, compared to 78 percent of the high-income elderly.

There is, however, much less variation in terms of the group that only has medicare—23 percent for the poor, and 14 percent for the high-income—and the reason, of course, is that the poor and other low-income groups are much more likely to have some other form of public insurance, particularly medicaid.

To begin the discussion, I would like to point out a few demographic characteristics about the elderly poor population. In brief, those who have either medicaid or private insurance are more likely to be female. Nonwhites are much less likely to have private insurance. Only 5 percent of the people with private insurance are nonwhite, compared to 21 percent of the medicare-only group. Those who are 75 years of age and older are a little less likely to have supplementation to medicare, and also, those who lack supplementation are a little more likely to be living with a spouse.

There are some differences in terms of the health status of these three groups of the elderly poor population. When you look at them in terms of how they categorize their health themselves, their ability to perform usual activities or outside activities, or the elderly with 8 or more bed-days, you find that those on medicare and medicaid are generally sicker than those with private insurance or only on medicare. There are, however, very few differences between those with private insurance supplementation and those who have only medicare.

When you look at the utilization experience, it is clear that insurance has had a very major impact on the use of health services by the elderly poor. Those who do not have additional coverage to supplement medicare average only 4.2 physician visits per year. This compares to 7 visits for the medicare/medicaid group and 6½ visits for those with medicare and private insurance. In fact, those in the medicare-only group have about the same number of physician visits as all persons between the ages of 25 and 54, a group that is presumably in much better health than the elderly poor.

Similar differences are found when you look at prescription drugs. Those with medicaid that supplement their medicare filled an average of more than 15 prescriptions, while those with only medicare had about roughly half, about 8 prescriptions. The elderly with private insurance had more than 12 drug prescriptions. Similar but smaller differences were observed in terms of hospital stays.

What we see is that the medicare-only group had much lower utilization levels than did the other groups. Those with medicaid are sicker, which might explain their differential use. However, the health status of the privately insured group is very similar to that with the medicare-only group, and this would indicate that the use differences between the medicare-only group and the privately insured elderly are primarily a function of financial barriers rather than different health statuses.

There are also differences in terms of out-of-pocket expenses. The medicare/medicaid group had relatively low out-of-pocket expenses, as one might expect, with their per capita expense in 1977 about $97. Using the medical care component of the CPI, we estimate their 1982 out-of-pocket expense at about $157.

The medicare-only group had a much higher expense. We estimate they paid about $290 out of pocket in 1977, and about $470 in 1982. Even higher expenses are found among the elderly poor who have private insurance. When you look at their direct out-of-pocket expense, their private insurance premiums, and their SMI coverage, we estimate that the out-of-pocket health care costs of this group of elderly poor was about $488 in 1977 and over $800 in 1982.

The purpose of increased cost sharing which you and other Members of Congress are considering is to reduce the Federal share of medicare, but also as you so correctly mentioned, to influence the behavior of individuals and to lower overall expenditures on health care for the elderly. Whether or not increased cost sharing is likely to have a significant effect on the Federal share of medicare is beyond the scope of this paper. What is clear, however, is that the basic problem is not how to control the health care costs of the elderly as much as how to control the rapid rate of increase in all health care costs in the United States and how to protect the poor, particularly the elderly poor, in the process.

The analysis I have discussed here compares levels of illness, use of health services, and out-of-pocket expenses among the elderly poor who supplement their medical care coverage either with public or private insurance and those who do not. The latter group is of particular concern given the current interest in cost sharing as a way of reducing the Federal share of medicare costs. While we have not tried to estimate the effects here of increased cost sharing directly, the figures discussed suggest that increasing cost sharing could raise serious problems for the low-income elderly. With the exception of those receiving medicaid, the elderly poor already appear to be facing considerable hardships. Those with only medicare coverage incur substantial out-of-pocket expense, which may account for the comparatively low levels of health service utilization given their health status. The elderly poor with private insurance do not appear to be similarly deprived of health services, but their ability to obtain health care appears to carry a very heavy financial cost. Absorbing additional out-of-pocket expense from increased cost sharing is likely to be very difficult for them.

We suggest that if increased cost sharing in the medicare system is enacted that careful consideration be given to exempting the almost 6 million poor and near-poor medicare beneficiaries. Such an exemption might prove to be particularly important to those who lack supplementary coverage, since this group already appears to be using substantially fewer physician, drug, and hospital services given their health status.

Chairman HEINZ. Dr. Wilensky, thank you very much.

[The prepared statement of Dr. Wilensky follows:]

PREPARED STATEMENT OF DR. GAIL R. WILENSKY

Mr. Chairman and members of the committee, it is an honor to appear before you today.

I am here as a researcher. Although I work for the National Center for Health Services Research and thus for the Department of Health and Human Services, I do not speak for the Department and my remarks should not be interpreted as such. I will be presenting information based on a paper prepared by myself and Marc Berk which I would like submitted for the record.[1]

There is a general consensus that since the enactment of medicare in 1965, the health care of the elderly has improved substantially. In 1958, 32 percent of those 65 years of age or more did not see a physician. This was reduced to 24 percent by 1970 and to 21 percent by 1976.[2] Moreover, during this time period, mortality among the aged has also been decreasing. Since this mortality decline began prior to the advent of medicare, it is difficult to determine how much of the decline in mortality among the aged is due to improved medical care and how much is due to improvement in other factors which affect longevity. It is clear, however, that the medicare program has had a dramatic effect on the manner in which medical care for the elderly is used and paid for. This is particularly evident for the poor and near-poor elderly who are more likely to be dependent on Government health programs.

The analysis I will present today focuses specifically on the role of public insurance programs for those elderly whose incomes are less than 125 percent of the poverty line. In this analysis, the poor elderly population are categorized into three groups. The first group consists of the approximately 1.4 million medicare beneficiaries who lack private health insurance and do not receive medicaid assistance. The second group includes medicare recipients who also have medicaid but who lack any private coverage. In 1977 there were approximately 1.5 million such beneficiaries. The third group is the 3 million poor elderly Americans who have private or CHAMPUS coverage to supplement their Government-financed insurance. Although the focus of this presentation is on the poor elderly, it should be noted that there are substantial differences across income groups in the relative numbers of elderly who supplement their medicare with other types of insurance, particularly with private insurance. Overall, 66 percent of the elderly supplement their medicare with private insurance. However, this percentage varies substantially across income groups with 47 percent of the poor/near poor having private insurance compared with 78 percent of the high-income elderly. There is much less variation across income groups among those with "only medicare"—from 23 percent for the poor to 14 percent for the high income. The reason is that the poor and other low-income groups are much more likely to have other forms of public insurance, particularly medicaid.

DATA SOURCES

The data used in this analysis come from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. The survey was undertaken to provide data for research currently being conducted by the National Center for Health Services Research and was cosponsored by the National Center for Health Statistics.

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[1] "Medicare and the Elderly Poor" by Gail Wilensky and Marc Berk, National Center for Health Services Research.

[2] Aday, L., Andersen, R., and Fleming, G., "Health Care in the U.S., Equitable for Whom?" Beverly Hills: Sage 1980, p. 100.

The sample and design of the surveys and the instruments and procedures are described elsewhere (Bonham and Corder; Cohen and Kalsbeek 1981).[3] [4] Information on types of insurance coverage, use of health services, expenditures, and sources of payment for each service by type of service, and the number of types of disability days was collected every 2 to 3 months from a national sample of 40,000 individuals. Extensive economic and demographic data concerning the sample was collected as well. Specific information on the way in which particular variables used in this paper were constructed can be obtained from the authors.

PROFILES OF INSURANCE GROUPS

Table 1 provides some basic demographic data on the characteristics of the poor elderly according to the three insurance groups. Those whose medicare coverage is supplemented by either medicaid or private insurance are more likely to be female than are those with medicare only. Nonwhites are much less likely than whites to have private coverage; they comprise 21 percent of the medicare-only group and 34 percent of the medicare and medicaid group but only about 5 percent of the group with private insurance. The people 75 years of age and older are a little less likely than those in the 65 to 74 age cohort to supplement medicare. Those who lack supplemental coverage are also more likely than others to still be living with a spouse.

TABLE 1.—DEMOGRAPHIC CHARACTERISTICS OF THE POOR AND NEAR-POOR ELDERLY BY INSURANCE COVERAGE: UNITED STATES, 1977

	Total population	In percent			
		Female	Nonwhite	Age 75-plus	Married living with spouse
Medicare only	1,364,000	62.6	21.0	50.2	36.4
Medicare and medicaid	1,484,000	74.8	33.9	45.3	20.3
Private and CHAMPUS	3,031,000	77.7	5.4	46.2	28.3

Source: National Medical Care Expenditure Survey, National Center for Health Services Research.

HEALTH STATUS

Three indicators of health status were used in comparing the different insurance groups. First we examined the proportion of people that considered themselves in fair or poor health. Although such a measure is subjective, it has previously been shown that such assessments by the elderly are closely correlated with the evaluations made by their physicians.[5] [6] We also examined the ability to perform usual activity or outside activities as well as the number of elderly people with 8 or more bed days. Finally, we considered those people who indicated a health problem on any of these three indicators.

The findings reported in table 2 show that the population with both medicare and medicaid is generally sicker than those with private insurance or those with only medicare. There were, however, no major differences in health status between those with private insurance and those who depend on medicare.

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[3] Bonham, G. and Corder L., National Medical Care Expenditure Survey: Household Interview Instruments, "Instruments and Procedures 1," Hyattsville, National Center for Health Services Research, 1981.

[4] Cohen, S. B. and Kalsbeek, NMCES Estimation and Sampling Variances in the Household Survey, "Instruments and Procedures 2," Hyattsville, National Center for Health Services Research, 1981.

[5] Blazer, D. G. and Houpt, J. L. "Perception of Poor Health in the Healthy Older Adult" Journal of the American Geriatrics Society 27:330, 1979.

[6] Maddox, G. L. and Douglass, E. B. "Self Assessment of Health: A Longitudinal Study of Elderly Subjects." Journal of Health and Social Behavior 14:87, 1973.

TABLE 2.—HEALTH STATUS OF THE POOR AND NEAR-POOR ELDERLY BY INSURANCE COVERAGE: UNITED STATES, 1977

[In percent]

	With fair or poor perceived health status	Limited in activity	With 8 or more bed days	With any of the 3
Medicare only	37.4	31.9	24.5	60.6
Medicare and medicaid	50.5	45.3	39.3	77.3
Private and other	33.0	30.5	27.5	60.3

Source: National Medical Care Expenditure Survey, National Center for Health Services Research.

UTILIZATION

It is clear that insurance coverage has a major impact on the utilization of health services by the poor elderly as shown in table 3. Those who do not have additional coverage to supplement medicare average only 4.2 physician visits a year. This compares to 7 visits for the medicare and medicaid group and 6.5 visits for those with private insurance. In fact, those in the medicare-only group have about the same number of physician visits as all persons between 25 and 54 years of age, a group that is presumably in much better health than the poor elderly. The role of supplementary insurance in explaining the use of physician services by the elderly poor is made even clearer by the use of multiveriate analysis. What we find is that after holding constant for health status, age, and sex, the elderly poor with medicaid have about one more physician visit on average than those with private insurance whereas the elderly poor with only medicare have about two visits less.

TABLE 3.—UTILIZATION OF HEALTH SERVICES BY THE POOR AND NEAR-POOR ELDERLY BY TYPE OF INSURANCE COVERAGE: UNITED STATES, 1977

	Mean number physician visits	Mean number prescription drugs	Percent with hospital stay
Medicare only	4.2	8.7	18.0
Medicare and medicaid	7.0	15.3	23.3
Private and other	6.5	12.2	22.0

Source: National Medical Care Expenditure Survey, National Center for Health Services Research.

Similar differences were found when the use of prescription drugs was considered. Those with medicaid to supplement medicare filled an average of more than 15 prescriptions while those with only medicare had 8.7. Elderly people with private health insurance had an average of more than 12 drug prescriptions. Differences in the probability of having a hospital stay were also observed. Over 22 percent of those with medicaid or private supplementary coverage had a hospital stay compared to 18 percent of those with only medicare.

The medicare-only group therefore had much lower utilization levels than did the other groups. The elderly with medicaid and the elderly with private had generally comparable levels of utilization. The difference between the medicare-only group and the elderly with medicaid can be attributed, at least partially, to the poorer health status of the medicaid elderly. The health status of the privately insured group, however, was very similar to that of the medicare-only groups. This would indicate that the utilization differences between the medicare-only group and the privately insured elderly are primarily a function of the financial barriers to care experienced by those lacking supplementary private coverage.

OUT-OF-POCKET EXPENSES

Out-of-pocket expenses for the poor and near poor are shown in table 4. Those with medicare and medicaid but no private insurance had relatively low out-of-pocket expense; their per capita expense was $97 and by using the medical cost component of the Consumer Price Index, we can estimate their 1982 out-of-pocket expense at $157. The medicare-only group had much higher expense. We estimate they paid $290 out of pocket in 1977 and $470 in 1982. Even higher out-of-pocket expense is found among those with private health insurance. They paid $329 in out-of-pocket expenses in 1977 and we estimate the per capita costs in 1982 to be almost $533. In addition, they paid an average of $105 out of pocket for health insurance premiums. Using the medical care component of the CPI to adjust our figures, this would be equivalent to $170 in 1982. Including the SMI premium, the out-of-pocket health care cost of the poor elderly with private insurance was about $488 in 1977 and about $810 in 1982.

TABLE 4.—OUT-OF-POCKET EXPENSE BY THE POOR AND NEAR-POOR ELDERLY BY TYPE OF INSURANCE COVERAGE: UNITED STATES, 1977

	Mean out-of-pocket expense	
	1977	1982 (estimated)
Medicare only	$290	$470
Medicare and medicaid	97	157
Private and CHAMPUS	329	533

Source: National Medical Care Expenditure Survey, National Center for Health Services Research.

CONCLUSIONS

The purpose of increased cost-sharing for medicare is both to reduce the Federal share of medicare and to lower overall expenditures on health care for the elderly. Whether or not increased cost-sharing is likely to have a significant effect on the Federal share of medicare is beyond the scope of this paper. What is clear is that the basic problem is not how to control the health care costs of the elderly as much as how to control the rapid rate of increase in all health care costs in the United States and how to protect the poor, particularly the elderly poor, in the process.

The analysis presented here compares levels of illness, use of health services, and out-of-pocket expenses among the elderly poor who supplement their medicare coverage with public or private insurance and those who do not. The latter group is of particular concern given the current interest in increased cost-sharing as a way of reducing the Federal share of medicare costs. While we have not tried to estimate the effects of increased cost-sharing directly, the figures discussed here suggest that increased cost-sharing could raise serious problems for the low-income elderly.

With the exception of those receiving medicaid, the elderly poor already appear to be facing considerable hardships. Those with only medicare coverage insure substantial out-of-pocket expense, which may account for their comparatively low levels of health service utilization. The poor elderly with private insurance do not appear to be similarly deprived of health services, but their ability to obtain health care appears to carry a heavy financial cost. Absorbing additional out-of pocket expense from increased cost-sharing will be very difficult for them.

We suggest that if increased cost-sharing in the medicare system is enacted, careful consideration be given to exempting the almost 6 million poor and near-poor medicare beneficiaries. Such an exemption might prove to be particularly important to those who lack supplementary coverage since this group already uses substantially fewer physician, drug, and hospital services.

Chairman HEINZ. Dr. Davis, we welcome you back. Please proceed.

STATEMENT OF DR. KAREN DAVIS, BALTIMORE, MD., CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY

Dr. DAVIS. Thank you, Mr. Chairman and members of the committee. I am delighted to be here, and thank you for this opportunity to testify on the status and the future of the medicare program.

Thirty million Americans depend on medicare to finance their medical care bills. These elderly and disabled Americans include those with limited financial resources, those with the most serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. Careful thought should be given to any fundamental changes in the program, especially those that would increase the burden on many of our most vulnerable citizens. To contribute to the consideration of alternatives to assure the adequacy and financial soundness of the medicare program, I would like to review the health needs and financial resources of medicare beneficiaries and the adequacy of the current medicare program; comment on the Reagan administration medicare proposals and CBO alternatives; and then end with a new approach to financing the medicare program that would merge the existing parts A and B of the program and change the financial structure by relying on an income tax surcharge.

To begin with, the elderly are not a homogeneous population. Some are very sick; others are relatively healthy. As a result, medicare expenditures are very skewed. In 1978, 77 percent of the elderly had virtually no health care expenses under medicare, less than $500 per person. On the other hand, 9 percent of the elderly accounted for 70 percent of medicare's expenditures on the aged, with an average bill of over $7,000. So you get a range from relatively healthy to very sick.

Chairman HEINZ. Dr. Davis, is it not true that many of those are terminally ill medicare beneficiaries?

Dr. DAVIS. Some of them are; about 6 percent of medicare beneficiaries die in a given year, and account for 31 percent of medicare expenditures, so that is certainly part of the problem.

The second point I would like to make is that the elderly as a whole are not a prosperous group. Half of all families with an elderly member have incomes below twice the poverty level. That is contrasted with 30 percent for the nonelderly.

The next point is that while medicare and medicaid are extremely important to the elderly and disabled in meeting their health care bills, they still leave the elderly picking up a large share of their own bills. Medicare picks up 40 percent of bills; medicaid, another 14 percent, for those 3.5 million aged who are covered by medicaid. But the rest is not picked up, that comes to $1,130 per aged person in 1981, that the elderly had to spend on their own health care bills.

With the cuts that have been made in medicare and medicaid in the last 2 years, the financial burdens on the elderly and disabled are undoubtedly even greater today.

I would like to comment briefly on the Reagan administration medicare proposals. The centerpiece of the budget for this administration for this year is labeled, "restructuring medicare cost-sharing." While billed as a benefit to the aged, in fact, most aged would face substantially greater health care bills; 7½ million sick, disabled, and elderly patients would face higher payments for hospital care. For example, an elderly couple with a $7,000 income—and about half of the hospital care in 1977 went to people with incomes below $7,000—could easily pay more than $3,000 for health care, $1,500 for hospital costs, $1,500 for physician services, prescription drugs, and other benefits that are not covered by medicare. The major financial burden would be felt most heavily by the 30 percent of the aged who do not have the supplementary private health insurance or medicaid coverage, as Dr. Wilensky described.

The administration argued that the burden of higher cost sharing could be offset by improved catastrophic coverage for the elderly. They would remove the limit on hospital days, but that would benefit only 150,000 medicare beneficiaries, contrasted with the more than 7 million medicare beneficiaries who would face higher payments under the coinsurance provision. Furthermore, even with this limit, it would not really provide catastrophic protection to all of the elderly, because it would not include physician charges, nursing home care, and other benefits.

The administration has proposed increasing the premiums and deductibles under the medicare program. Changes that have been made in the last 2 years, have added costs to the elderly of $9.3 billion for the period from fiscal 1984 to 1988. The new proposed deductible increases would add another $1.1 billion to payments by the elderly over this period.

We should note that prior to these changes, medicare only picked up 54 percent of the phyisician bills of the elderly. So as you increase the deductible, you are going to get down to less than half of all physician bills being paid by medicare.

The administration is also proposing a voluntary voucher program, which would provide the elderly with a voucher equal to about 95 percent of the cash value of medicare. That is not a cost saver; that is an additional cost. In part, it is likely to be more costly because private health insurance administrative expenses are higher than medicare, and also because their reimbursement rates for hospitals and doctors do not have the limits that medicare has. Another problem with the voucher proposal is that it is likely that only very healthy elderly would select it——

Chairman HEINZ. Excuse me—this will not count against your time—but at the top of page 5, when you say there are 7 million beneficiaries who face higher charges; there are 29 million beneficiaries in the program. Is that because on the average, only about 1 out of every 4½ beneficiaries actually incurs, on the average, an annual cost benefit?

Dr. DAVIS. That is exactly right. Only about 20 to 25 percent are hospitalized in a given year. So when we talked about the skewing before, one of the reasons they are very high is that it is that fraction that is hospitalized sometimes for a very long time.

Chairman HEINZ. Thank you.

Dr. DAVIS. So the voucher would lead to adverse risk selection; in other words, people who are very healthy might take the voucher, and those who are very sick—those that are hospitalized—are likely to stay with medicare, and that would result in higher costs to the program.

The administration has also proposed a so-called freeze on physician charges under medicare. Actually, it does not freeze what the physician can charge, it only freezes what medicare pays. Since there is not mandatory assignment under medicare, that higher charge would just be borne by the elderly. Medicare would pay less, but the beneficiary would pay more.

I would like to turn to the three alternatives that Dr. Rivlin set before the committee today to deal with the long-term deficit in the hospital insurance trust fund. She mentioned there are basically three alternatives that the Congress might want to consider: Tighter hospital prospective payment rates; increased hospital coinsurance; or increases in the HI payroll tax rate. And she noted that to eliminate the $300 billion deficit that they project for 1995 would require fairly stringent measures if you adopted any one of these three alternatives. She suggested that some combination may be necessary.

Let me review those three alternatives. There is clearly some leeway for eliminating at least half of the deficit through tighter hospital prospective payment rates, even beyond the legislation that was recently passed by the Congress. As new experience with that system is gained—and we are talking in years about 1987-88 when the deficits in the trust fund start—if one tightens the rate of increase in those prospective hospital payments to hospital "market basket" inflation, plus another 1.6 percentage points, you could eliminate half of the deficit that is projected. And I think that is not an unreasonably tight limit for the hospitals. It is a little bit higher than what the Carter legislation would have proposed and a little bit higher than what the hospital industry voluntary effort set as their own goal after 1979.

Chairman HEINZ. But you do not mean plus 1.6 percent; you mean minus 1.6 percent.

Dr. DAVIS. I actually mean plus. By "market basket" inflation, I am just talking about the wage rate increases of the hospitals and their other input costs. I am allowing another 1.6 percentage points for service expansions, new technology, upgrading the quality of care. So it would be in addition to just taking care of the higher costs that they have to pay for certain goods and services that they purchase. This plus 1.6 percent would allow for new technology, and research.

Chairman HEINZ. So just by coincidence, you have added 1.6 percent, that that happens to be the number that gets you to half——

Dr. DAVIS. Half, yes. That is what CBO estimates would eliminate half of the deficit.

Chairman HEINZ. I just wanted to be clear on that myself.

Dr. DAVIS. Yes; it is the CBO estimate of what it would take to eliminate half of the deficit.

Senator MELCHER. Dr. Davis, why are you so confident that prospective payments would decrease the costs?

Dr. DAVIS. I think that if one went to these tighter payments, one would have to look at across-the-board limits rather than the medicare only limits which the administration proposed and the Congress enacted.

I think if one wants to really make limits effective as a cost-containment device, then one needs to move toward prospective payment limits on privately insured patients, as well. To achieve these kinds of things, you need to go across the board.

Senator MELCHER. Well, I have assumed, and I think accurately, that you are not talking about any decrease in services available within the hospital.

Dr. DAVIS. We are talking about slowing the rate of acquisition of new technology. It would permit the current level and quality of care. But one of the reasons hospital costs have been going up so fast is that they have been duplicating equipment and expanding technology. It would curb the rate at which that happens.

Senator MELCHER. Well, then, my assumption is inaccurate. You are not assuming that the best possible care will be given to the patient.

Dr. DAVIS. I think there is a lot of room for improvement in quality, even within these limits. But I think that there is an opportunity, to reduce some of the waste and duplication that occurs under the current system. Some of the stringency would come there.

Senator MELCHER. Is there something other than previous studies that indicate that duplication is excessive?

Dr. DAVIS. There are six States that have set these kinds of limits, and what we found in those States is that the quality of care has remained high, and they have been able to adopt new technology and expand services, even with more effective overall constraints.

Senator MELCHER. Thank you.

Dr. DAVIS. So tighter hospital payments could eliminate half of the deficit. The other two CBO alternatives to eliminate the deficit are basically higher payroll tax rates or higher hospital coinsurance. I think over time, it is going to be difficult to put more burden on the payroll tax because it is already high, and because the number of old people will increase much faster than the number of new workers entering the work force. It is going to be a strain to try to finance the medicare program out of the payroll tax because of that underlying demographic change.

The final CBO alternative for eliminating the deficit through raising the hospital coinsurance, is even less attractive. It means that the 20 to 25 percent of the elderly and disabled who are hospitalized every year would have to pay to pick up that deficit. That could mean putting charges as high as $8,000 on a hospitalized person in 1995.

So I would like to end with another option for the committee to consider, namely, a fundamental reform of the way medicare is financed. The way medicare is currently financed is largely a historical accident. Coverage for hospital care is mandatory and is financed by payroll tax; coverage for physician services is voluntary and financed by a combination of premiums and general revenues. Both are important, and both are of equal concern in terms of the budget.

I would like to propose merging the HI and SMI parts of medicare into a single plan with integrated financing and administration; retaining the current payroll tax and general revenue contributions to this fund, but replacing the SMI premium with an income tax surcharge on medicare beneficiaries. At the time they are merged, one could change the cost sharing to have a single deductible, coinsurance, and maximum cost-sharing ceiling across all medicare benefits. One could also make some changes in the medicaid program to provide supplementary coverage for low-income medicare beneficiaries.

But the main shift is switching from a premium to an income tax surcharge to finance the medicare program. This is a far more equitable way of financing the deficit than loading up charges on elderly who are hospitalized.

About 85 percent of all taxes paid by the elderly are paid by elderly with incomes over $20,000, so it would be this group that would pay most of the incremental costs for reducing the deficit with an income tax surcharge.

Elderly families with incomes below $5,000 currently pay none of the income tax for the elderly, so they would be spared premiums under this proposal.

This is a new departure. I am not suggesting that it be quickly adopted without careful review. I think it does need to be carefully costed out, and explored, the administrative efficiencies and difficulties examined, and the distributional impact on the poor and the nonpoor, the sick and not-so-sick determined. But I think it is important to keep before the Congress a broad array of options, and not just immediately focus on the three that CBO has set forth, which I think all have their limitations.

Thank you.

Chairman HEINZ. Dr. Davis, thank you very much.

[The prepared statement of Dr. Davis follows:]

PREPARED STATEMENT OF DR. KAREN DAVIS

FINANCING MEDICARE: A NEW APPROACH

Thank you, Mr. Chairman, for this opportunity to testify on the status and future of the medicare program. Thirty million Americans depend on medicare to finance their medical care bills. These elderly and disabled Americans include those with limited financial resources, those with the most serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. Without an adequate medicare program, many of these vulnerable people would be financially devastated and some would simply be unable to obtain medical care necessary for relief from pain, suffering, disabling, and life-threatening conditions. Careful thought should be given to any fundamental changes in the program, especially those that would increase the burden on many of our most vulnerable citizens.

To contribute to the consideration of alternatives to assure the adequacy and financial soundness of the medicare program, I would like to:

Review the health needs and financial resources of medicare beneficiaries, and the current adequacy of the medicare program;

Comment on Reagan administration medicare proposals and CBO alternatives; and

Present a new approach to financing the medicare program that would merge the hospital insurance (HI) and supplemental medical insurance (SMI) parts of medicare and replace the SMI premium with an income tax surcharge on medicare beneficiaries.

I. Health Needs and Financial Resources of Medicare Beneficiaries

The elderly and disabled are not a homogeneous population. Among their numbers are very sick individuals with high medical care bills. For some of the chronically ill, high medical care needs continue year after year. Others are healthy and vigorous and use medicare benefits only rarely. Yet, for these people medicare provides peace of mind, secure in the knowledge that they will be protected should they become ill or suffer an accident.

Because medicare beneficiaries are so different, health expenditures for this group are very skewed. In 1978, 77 percent of the elderly had annual medicare reimbursements of less than $500, including 40 percent of the elderly who had no medicare payments. At the other extreme are those elderly who require extensive care and treatment. Nine percent of the elderly accounted for 70 percent of all medicare payments, with an average payment of over $7,000 in 1978.

The elderly, for the most part, are not a prosperous group. Half of all families with an elderly member have incomes below twice the poverty level. (In 1981, the poverty level for an aged individual was $4,359; twice the poverty level was $8,718.) By contrast, 30 percent of persons in families without an aged member have family incomes below twice the poverty level. In 1981, 15.3 percent of the aged had incomes below the poverty level, compared with 14 percent for all persons. For single, white, aged women, 28 percent had incomes below the poverty level, while 64 percent of single, black, aged women had incomes below the poverty level.

Medicare, and the medicaid program, are extremely important to the elderly and disabled in meeting their health care bills. Together in 1981, the programs spent $61 billion on health care for the elderly and disabled. Seventy percent of medicare payments go for hospital care. Seventy-two percent of medicaid expenditures assist the elderly and disabled.

Despite these programs, many elderly and disabled already face serious financial burdens in meeting their health care expenses. In 1981, medicare met only 45 percent of all health expenditures of the aged. Medicaid filled in another 14 percent, covering 3.5 million aged or 14 percent of all aged. With required medicare cost-sharing and excluded benefits, the aged spent an average of $1,130 per person privately on health care expenditures in 1981.

With the cuts in medicare and medicaid that have been made in the last 2 years, financial burdens on the elderly and disabled are undoubtedly greater today. Deductibles under medicare for both hospital and physician services have been increased, resulting in an added cost to medicare beneficiaries of $1 billion in fiscal year 1983. The premium for medicare physician services has been raised, increasing the cost to medicare beneficiaries by another $1 billion in fiscal year 1984 to fiscal year 1986.

II. Reagan Administration Medicare Proposals

On top of past cuts, the Reagan administration is now proposing another $11 billion in medicare and medicaid cuts for fiscal year 1984 to fiscal year 1986. Nearly all of these would fall directly and immediately on the elderly, disabled, and poor.

Medicare hospital cost-sharing

The centerpiece of the administration's health budget is labeled "restructuring medicare cost-sharing." While billed as a benefit to the aged, in fact most aged would face substantially greater health care bills. Seven and one-half million sick disabled and elderly patients would face higher payments for hospital care. An elderly couple with a $7,000 income (and half of the hospital care received by the elderly in 1977 went to people with incomes below $7,000) could easily pay more than $3,000 for health care—including over $1,500 in hospital charges and $1,500 in physician charges, prescription drug fees, and charges for other health care services not covered by medicare. The major burden would be felt most heavily by the 30 percent of the aged without supplementary private health insurance of medicaid coverage—predominantly near-poor elderly.

Catastrophic coverage

The administration argues that the burden of higher cost-sharing would be offset by improved catastrophic coverage for the elderly. Removal of limits on days of hospital coverage under medicare, while important, would benefit only 150,000 medicare beneficiaries, contrasted with the more than 7 million beneficiaries who would face higher charges. Even under the proposal, the elderly would be vulnerable to catastrophic expenses for physician charges, nursing home care, private duty nursing, prescription drugs, long-term mental health care, and other benefits uncovered or only partially covered by medicare.

Premiums and deductibles for physicians' services

Despite the major increases in premiums and deductibles for physicians' services already enacted in the last 2 years, the administration is proposing to collect $9.3 billion from the elderly and disabled from fiscal year 1984 to fiscal year 1988 through higher premiums. Deductibles for physician services would also increase by $1.1 billion over this period. Prior to the 1981 changes, medicare paid only 54 percent of physician bills of the elderly; the proposed changes would reduce medicare's share to below half of all elderly physician bills.

Voluntary medicare voucher

The administration proposes to give medicare beneficiaries the option of using 95 percent of the cash value of medicare to purchase private health insurance. The administration estimates that this would cost $50 million in 1984. There is little evidence that private health insurance would be less costly than medicare. In fact, the opposite would appear to be true:

> Private health insurance administrative expenses average 10 to 50 percent of benefit payments, compared with 3 percent for medicare.

Private health insurance plans do not have hospital and physician reimbursement limits built into medicare; and

It is likely that only very healthy elderly would opt for private health insurance coverage; a 95-percent voucher would exceed their cost to medicare; since 9 percent of the aged account for 70 percent of medicare's aged health expenditures while 75 percent of the aged have virtually no medicare expenditures, adverse risk selection is a potentially serious problem.

Medicare physician fee freeze

The administration professes to request a "freeze" on physician charges under medicare. This so-called "freeze," however, does not stop physicians from charging the elderly and disabled more. Instead they can simply charge what they wish with medicare beneficiaries picking up the difference between that charge and what medicare pays. Without mandatory assignment of physician services and a set fee schedule, there will be little effective control of physician expenditures or protection for the aged and disabled.

III. CBO Alternatives

The Congressional Budget Office (CBO) has estimated that the HI trust fund will incur large, and increasing, deficits over time. Even with the recently passed hospital prospective payment rates, the HI trust fund should be exhausted by 1988, and accumulated deficits should reach $300 billion by 1995. These deficits will occur because the number of aged is growing at a faster rate than new entrants to the work force (and hence payroll tax contributors) and because hospital costs tend to rise faster than wage rates (which affect payroll tax contributions).

CBO has set forth three alternatives that would eliminate this deficit:

Tighten hospital prospective payment rates to increases equal to hospital "market basket" inflation less 1.6 percentage points a year; or

Increase hospital coinsurance gradually to 33 percent by 1995; or

Increase the HI payroll tax rate gradually from 1.45 percent under current law to 2.38 percent in 1995.

CBO has noted that some combination of these alternatives could be used, lessening the stringency of each.

Some additional savings could be achieved through tighter hospital prospective payment rates, as experience with the new system is gained. It would not be unreasonable to eliminate half of the deficit in the HI trust fund with allowable increases in prospective rates per admission of hospital "market basket" inflation *plus* 1.6 percentage points a year. This is approximately the same degree of stringency as proposed in the Carter hospital cost containment bill (which allowed "market basket" inflation plus 1 percentage point with some exceptions) and the same degree of stringency proposed by the hospital industry voluntary effort in 1979. Such an allowance would permit hospitals to keep up with general inflation and to improve services and quality of care at a gradual rate over and above increases for inflation.

The increase in payroll tax clearly could be absorbed, but the payroll tax is a regressive tax that falls heavily on workers. With the increase in the ratio of elderly people to workers in coming decades, excessive reliance on the payroll tax to finance services for the elderly should be avoided.

The remaining CBO alternative is even less attractive. Eliminating the deficit by raising hospital coinsurance would place all of the burden on the 20 percent of the elderly and disabled who are hospitalized during a year, and an especially heavy burden on those seriously ill elderly and disabled with long hospital stays or multiple hospital episodes. Such an approach amounts to eliminating the deficit by placing a hefty tax on the very sick. If half of the deficit were eliminated with higher hospital coinsurance, the average additional cost to hospitalized medicare beneficiaries in 1995 would be over $4,000. For the 8 to 10 million elderly with incomes below twice the poverty level who are not covered by medicaid, additional payments of this magnitude would be unbearable. It should be remembered that half of all aged hospital care in 1977 was received by people with incomes below $7,000, and it is just this group that is least likely to have supplementary private health insurance to help meet these costs. Hospital coinsurance, as a financing device to reduce deficits, is one of the most inequitable taxes that could be designed—falling disproportionately on the very sick and the poor.

IV. Financial Reform of Medicare

The current financing structure of medicare is largely a historical accident. Coverage for hospital care is mandatory, and is financed by a payroll tax. Coverage for physicians' services is voluntary and financed by a combination of premiums and general revenues. Physician services are no less essential to the health and well-being of the elderly and disabled than are hospital services.

Splitting medicare into separate parts does not facilitate sound health or fiscal policy. In the current concern over the HI trust fund, 18 to 20 percent a year annual increases in SMI physician expenditures are largely ignored. Budgetary deficits created by hospital expenditures financed by a payroll tax are not inherently more disturbing than budgetary deficits created by physician expenditures financed by general revenues. Sound solutions to projected medicare expenditures should clearly embrace all of medicare.

The following proposal for financing medicare is offered for consideration:

Merge the HI and SMI parts of medicare into a single plan with integrated financing and administration.

Extend medicare coverage automatically to all persons age 65 and above, and to disabled persons covered under current law.

Retain current payroll tax and general revenue contributions in a combined HI-SMI trust fund.

Replace the SMI premium with an income tax surcharge on medicare beneficiaries.

Keep the total patient cost-sharing of medicare at its current level, but replace current provisions with a single deductible and coinsurance rate for all covered services with a maximum ceiling on cost-sharing for beneficaries.

Gradually tighten hospital prospective payments over time to permit increases at no greater than hospital "market basket" inflation plus 1.6 percentage points; establish physician fee schedules with mandatory assignment.

Option—replace the medicaid program for low-income medicare beneficaries with a "wraparound" policy covering the cost-sharing requirements of medicare and expanded benefits for long-term care, prescription drugs, etc., financed by Federal and State general revenues; and

Option—permit nonpoor medicare beneficiaries to purchase the "wraparound" policy for a voluntary additional income tax surcharge.

This proposal is a major departure from the current financing structure of medicare. It should be thoughtfully and carefully reviewed, and widely debated. The proposal, however, has several desirable features. The income tax surcharge would be a more equitable method of financing the deficit currently projected in the HI trust fund. If the income tax surcharge financed half of the projected deficit, with the other half coming from tighter prospective hospital payments, I estimate that it would require a gradual increase in the average tax burden of the elderly and disabled to roughly 6 percent of adjusted gross income by 1995.

Unlike higher hospital coinsurance, the income tax surcharge would be equitably distributed. A constant income tax surcharge for all elderly would fall primarily on those elderly with adjusted gross incomes in excess of $20,000. Approximately 85 percent of the tax would be paid by this group, while almost none of the tax would fall on elderly and disabled with income below $5,000.

Similarly, the integrated cost-sharing structure could redistribute the current financial burden of medicare more equitably among the sick and the not-so-sick. For example, a deductible of $150 plus coinsurance of 5 percent on all services with a catastrophic ceiling of $1,500 on all services would remove the high deductible for hospitalized patients and provide better protection against catastrophic expenses. Given the very high share of income already devoted by the elderly to out-of-pocket medical care bills, the basic intent of the restructured cost-sharing should be to avoid higher average burdens on the elderly.

The optional reform of the medicaid program for those beneficiaries covered by both medicare and medicaid paves the way for better integration and administration of these programs. The optional "wraparound" policy for other medicare beneficiaries is one way to finance long-term care and other services currently excluded from medicare for the nonpoor elderly.

These suggestions need to be more carefully costed, the administrative efficiencies or difficulties explored, and the distributional impact among the poor and nonpoor, sick and not-so-sick, examined. But, I hope this provides a constructive starting point for exploring a broader range of options for addressing the projected fiscal problems of the medicare program.

Thank you.

Chairman HEINZ. Senator Melcher, did you have any opening statement you would like to put in the record, or make at this time?

Senator **Melcher**. Well, I have a statement that I would like to have put in the record.

Chairman **Heinz**. It will be placed in the record without objection, at this point.

[The statement of Senator Melcher follows:]

STATEMENT OF SENATOR JOHN MELCHER

First, I want to commend the chairman for requesting the thorough CBO study and for following up with this oversight hearing on the possible coming crisis in medicare funding and options for change.

With excellent and comprehensive data before us, not only from CBO, but from the Rand Corp. and the National Center for Health Service Research, Congress has the opportunity to analyze the problem and make changes early enough to correct trends which would deplete the medicare trust fund by 1988.

The speedy passage of the prospective payment system for medicare hospital costs in the social security bill is an encouraging sign that Congress is addressing the medicare problem. The myriad of studies, reports, and demonstrations on other aspects of medical care costs and payment systems that Congress is requiring of the Secretary of Health and Human Services will extend the base for further solutions.

The last thing we need to do is to scare the elderly of this country into another unnecessary crisis situation affecting one of their most basic needs. We have just faced up to and provided solutions for the complex and controversial social security program. We can do the same with the medicare trust fund. And we must get at it long before we reach the crisis stage. Our Nation's senior citizens deserve no less.

Chairman **Heinz**. May I thank all distinguished doctors for some very helpful testimony. As you may have gathered from my comments to the previous witnesses, I believe that if we just ask what changes we would make in the medicare program to address medicare's financial problems, we are going to be asking the wrong question. We need to ask what changes we can make in the entire system to hold down costs. So the question I really have, the $64 question I have for the panel, and particularly you, Dr. Davis, is, What steps can we take to add incentives that would result in long-term savings to the entire health care system? What are your thoughts on that?

Dr. **Davis**. I think it is important to look at the entire health care system, but I would not downplay the importance of making changes in the medicare program, since it is a big share of the health care system, and with the increase in the elderly we will be seeing over the next couple of decades, it certainly will be a bigger share.

In terms of the entire health care system, I think the passage by the Congress of prospective hospital payment rates for medicare is an important step, and that what needs to be done at this point is to look at extending that to the privately insured patients, by setting prospective hospital payment rates for those with Blue Cross, Blue Shield, and private insurance coverage.

So, if I had to pick the one most important step, I think it is important to look at how we go about translating those new incentives, new types of payments to privately insured patients.

On the physicians' side, I think medicare is currently a long way away from even being what we should be doing and setting a model for the rest of the system. The current system has all kinds of inequities built into it—urban physicians get paid more than rural physicians, newly trained physicians get paid more than a long-term practicing physician. The current system of the lower of usual, customary, or prevailing fees is very complicated and creates a lot of inequities.

Moving toward a physician fee schedule in medicare and addressing the assignment issue so that the physicians cannot charge the elderly additional amounts on top of that fee schedule are very important steps.

If you are talking about very long-term changes, I think 5, 10 years from now—and what we need to be doing now is developing some of the research and methodology that will make it feasible 5 or 10 years from now, to move toward more of a capitation payment system for the providers. I am not talking just about HMO's, but even paying a hospital a fixed rate per person per year for hospital services, so that the hospital would have an incentive to care for patients in the community on an outpatient basis rather than an inpatient basis. One concern I think we all have about this new prospective hospital payment system is that it does give an incentive to hospitals to put more patients in hospitals. I think we need to be moving toward a capitation system, but part of the problem is how you set those rates to vary depending upon how sick people are. We do not really know how to do that very well.

Chairman HEINZ. A followup question, before I turn to other members of the panel. About 6 years ago, there was a proposal to place limits on revenues from all payers for hospitals, and that would have been indexed annually—hospital cost containment. I have reason to believe you may have some familiarity with that proposal.

Dr. DAVIS. I do recall it.

Chairman HEINZ. What is right with it, and what is wrong with it, in the light of 6 years' reflection?

Dr. DAVIS. I think that what the Congress has enacted is a good evolution out of that proposal. That proposal basically went across all patients and limited the rate of increase in allowable payments to, as I indicated, "market basket" inflation plus another percent or so.

This current proposal just applies to medicare, and I think that is a concern, that it will lead to cost shifting on the privately insured patients, and may lead eventually to two-class care for the elderly or, if you kept it in long enough, hospitals not wanting elderly patients.

But in terms of the approach, I think it is an improvement over what we were able to do or think about 4 or 5 years ago. We now have some of the data on case mix that permit us to go to a totally prospective approach. Back in 1977, we promised to get the kind of data and methodology to do that, and I am pleased to see that that is available. I think you can best compare the Carter administration approach to the TEFRA approach that was enacted last year for medicare, as opposed to across the board. The DRG is an improvement in the methodology beyond that.

I think there are going to be problems with the DRG proposal, and it will need to be improved and refined year after year. I am concerned that it does not really address the severity of the illness of patients in a given diagnosis category. I think it is going to have substantial impact on public hospitals and teaching hospitals that have the particularly sick patients and refinements will be required over time.

Chairman HEINZ. Let me ask the other members of the panel what they think we can do in the way of incentives here?

Dr. WILENSKY. I rather like the array that you mentioned earlier—tax capping, multiple choice from employers, equal dollar contribution.

Chairman HEINZ. You must know Allan Enthoven.

Dr. WILENSKY. Yes. I think that the set of programs you outlined will provide for an increased level of cost consciousness for both consumers and providers. I also agree with your point that one piece of the program might not do nearly enough and that there is a real advantage to having some level of sacrifice from many different segments of the population.

An additional point worth noting is that the incentive effects we have been discussing are likely to be self-reinforcing and multiplicative. This means that when we estimate these effects empirically, we are likely to produce very conservative estimates. Thus, for example, an estimate of the effect of a tax cap on employer contributions which is based only on observed experience is likely to substantially understate its effect on the type and depth of insurance purchased. We can, however, regard such estimates as representing the lower bounds of changes likely to be associated with various reforms.

My concern about the incentive approach is that it is not likely to affect the very high-cost care and the heroic measures associated with the last days of life, a point which Dr. Newhouse made, since it is unlikely that you will ever have individuals being responsible for the very high-cost illnesses nor would we want them to be.

Chairman HEINZ. I thought that was a very significant point that Dr. Newhouse made, and the point is well taken.

Dr. WILENSKY. What this means, is that in addition to a set of incentives for consumers and providers on the normal, acute care, we are likely to need some sort of regulation, perhaps a broader form prospective payment, which puts pressure on hospital behavior. This, in turn, is likely to affect the introduction of new technology and the use of complex or innovative procedures and the application of heroic measures. I do not know whether or not we can do this without affecting the quality of care. I think it is in fact likely that when you really put a squeeze on reducing hospital costs and other health care costs, that you may well begin to affect quality. What we need to do is to measure what we are getting at various prices, and to define the kinds of tradeoffs we are willing to make.

Chairman HEINZ. Dr. Newhouse, you kind of got shorted a little bit, when you got to the conclusion of your analysis. Please, feel free to elaborate on them, and any comments you have on my questions.

Dr. NEWHOUSE. Thank you. Well, there, are roughly three ways to go. We seem to have more or less ruled out relying exclusively on the first one, which is just to accept the increases, although we seem to be talking about accepting some of them.

The second one is the procompetitive approach. There are certainly parts of that, such as the tax cap, that I find, move in the right direction, but as I indicated, I do not think that that will much change the trend in hospital costs.

The third, the direction which we have touched on several times today, I think I would call regulation or prospective payment, or whatever term one wants to use. I think, as has come up, there are several technical issues with it. I would not propose to say much about them, but there are possibilities for manipulating the system; for example, if one reimburses dollars per stay, there may be more stays, put the patient out, bring the patient back in.

Karen alluded to the severity issue, with respect to diagnostic-related groups even with a diagnostic-related group, certain patients are sicker than other patients. Those patients may have a harder time getting care. Certain providers, in particular the teaching hospitals, are likely to have a harder time because they have more of those patients now.

I would like to say something about the part of my statement that I did not get to talk about. In that part I raise the issue of what is the give up; that is, what kind of benefits do we give up? Senator Melcher talked about this as is the effect on quality of care.

I frankly do not think we know a lot about that. For there to be very little or negligible give up, there would have to be A, a substantial amount of waste, and B, an instrument to really reduce the waste without much affecting the meat, or whatever it is we want. I am concerned about both of those assumptions. I think we frankly do not know much about who does not get treated for what, as we tighten these limits. I did give an example in my statement, which is admittedly an extreme example, that would not, I think, be applicable here, but it illustrates my point. That example is the comparison of the United States and United Kingdom renal dialysis rates. The United Kingdom's costs are much below ours—I think they are around 40 percent of our costs on a per-person basis. By any stretch, that is much below where we would propose to go, but it is certainly cost containment.

The rate of renal dialysis in the United Kingdom for people under 45 is about the same as it is in the United States, but among people over 65, it is about 10 percent of the United States rate. I can only conclude that those elderly who have kidney failure in the United Kingdom are really bearing some of the burden of cost containment in the United Kingdom. I also think, in fact, that there was a roughly similar situation here before the end-stage renal program, when machines were scarce and tended to get allocated differentially to the nonelderly. My point is, that there is likely to be some kind of give up, but I do not know very much about what that give up is. One could certainly argue that the give up is not worth the cost, but I frankly do not think we know very much about it.

Chairman **Heinz**. Dr. Newhouse, thank you very much.

Senator Melcher.

Senator **Melcher**. I do not think you get any decrease in these costs by creating more restraints, and I suspect all of you have thought about that. If a physician or, I would assume the same is the case with a hospital, has to start filling out a form to collect their money, they are going to fill every slot there and collect whatever is coming.

Will prepayments lead to less form filling out?

Dr. DAVIS. Senator, I think you have raised a good point about the importance of the physician in making decisions in the health care system and the need to involve the physician in that, and the capitation prepayment approach tends to get those kinds of incentives in place. Basically, I think what we have to do is look at the experience where we have paid on a prepaid basis—the evidence is that they have lowered cost. We find in the health maintenance organizations, where they are paid on a prepaid basis, like Kaiser, for example, that hospitalization rates are 30 to 60 percent lower than they are in other kinds of settings, and that the total cost is anywhere from 10 to 40 percent lower. What happens is that when you get paid the same amount whether you put somebody in a hospital or not, the organization finds ways of doing more things on an outpatient basis. Therefore, the diagnostic workup and the minor surgical procedure get done on an outpatient basis, and not inpatient.

Senator MELCHER. That is in itself an incentive, then?

Dr. DAVIS. Right.

Senator MELCHER. Dr. Davis, you are from Johns Hopkins. Forgetting about the hospitals—and I know they are a major cost item that we are talking about—but forgetting about the hospitals for a minute, has there been any evidence done by the university to show that Johns Hopkins graduates have increased their fees—well, I guess you would probably have to go on income level—have such a high income level compared to 10 or 20 years ago? That it is alarming?

Dr. DAVIS. I really do not know the income experience of physicians trained at Johns Hopkins Medical School. For the United States as a whole, physician incomes in the last 10 years have not gone up that much in real terms. I think that is true of all of us in all professions. But it does not seem to be the physician income per se. What we are concerned about, I think, and one of the issues that I think we will be increasingly concerned about, is that as we train more and more physicians, they find more and more things to do. What some of the studies conducted at Johns Hopkins have found is that those areas that are saturated with physicians, very high numbers of physicians, tend to have much higher hospitalization rates, and tend to have higher fees even—not lower fees—than where there are fewer physicians. Thus, the costs appears to be higher as a result of the supply. I think that is a problem for the future.

Senator MELCHER. Well, I think it is all too easy to slander and to literally throw mud at a very fine profession by saying they are getting too much "dough" and charging too much, and they do not make house calls anymore. Well, I know why physicians do not make house calls anymore, because they can give you better care in a hospital. I do not like to go to hospitals, but I realize from their standpoint they are going to advise you and coerce you, the patient, into doing what is best for the situation.

And I would think where there are more physicians, you will find more hospital costs—I think that is just normal. That is the way it should be. I believe you can get better care in the hospital, and therefore, if I were a physician, I would have my patient in the hospital. And I am amazed at how much time, at least, in my experience, physicians spend with their patients. To the contrary of what seems to be a lot of popular belief that they never come around and see you, I think they give an ungodly amount of their time to patients, as far as I have been able to observe personally, and I know they do that, seeing a number of patients in a hospital on the same visit. That is fine with me.

But hospital employees, at least as far as I know, are among the most underpaid, overworked people. Now, is there anything to the contrary? Have I missed something? Has there been any data that shows that all of a sudden, we have started paying hospital employees a comparable wage with what they might make somewhere else?

Dr. DAVIS. I think you are raising a number of good points. No one challenges that physicians are dedicated and find it more convenient to care for patients in hospitals——

Senator MELCHER. And they are more efficient and effective that way?

Dr. DAVIS. Certainly, from the point of view of their own time, to be able to walk down a hall——

Senator MELCHER. I mean for the patient.

Dr. DAVIS. I am not so sure about that, since it does mean the families have to come in and the patient is in an institutional environment, but certainly from the point of view of the physician. But on your point about the hospital employees, the evidence shows that they are not paid at higher rates than in other industries. What is happening is not so much that they are paid too much, but that hospitals keep adding more and more employees to provide a day of hospital care. In most industries, we have productivity gains, so that you can provide a given service or produce a given good with fewer hours of labor. In the hospital industry you get the reverse, negative productivity. Hospitals hire more and more people to provide a given level of care. Now, does that do some good? Well, maybe it does some good, but I think what we are faced with are the kinds of trends shown on the committee's charts. With 70 percent of medicare expenditures for hospital care and hospital costs are going up 18 to 20 percent a year, the demographic trends mean big financial problems for the Federal budget and for employers and others who have to pick up the tab for the cost of health care. You have to weigh the convenience to the doctor against the cost to society of that style of care.

Senator MELCHER. Well, I do not want to leave any misconceptions here. I think it is impossible for a physician to see a patient very often if he is not hospitalized, and I am not looking at the efficiency of the time of the physician, but I am just saying that it is impossible for a doctor to see a patient, say, twice a day, unless that patient is in the hospital. Presumably, that naturally is not true of anybody who can walk into the doctor's hospital. I am not talking about those types of cases. I am talking about the patient who will not be able to visit the doctor twice a day.

If it is my blood, I always resent when they want to draw it again—they just drew it last week; I do not know why that is not good enough. But maybe there is a reason for it. And I can visualize, I think, what that adds to the cost for that hospital.

I think what we are doing with hospitals is right. They are better than they ever were before, and they ought to keep making them better. I know that costs money, but over history, medicine has always been financed out of charity. I think we have transferred charity to the Treasury now, in many instances, and I do not find particularly anything wrong with that. I want all this new equipment, and I do not care whether there are six CAT scanners in Billings, Mont., or Missoula, or what-have-you. I would just as soon have six of them. I do not find that duplication to be repulsive or contrary to the public interest at all.

Dr. DAVIS. I think if one looks at the cost and says, "We are willing to pay it," then that is a decision one could make.

Senator MELCHER. Every sick patient is always willing to pay it, and all their families are always willing to pay it.

I think we have lost something here, over the past 30 years. We have had this explosion in technology, applied physics and applied engineering, and what-have-you, and I think it is excellent. But to pay for it, we have also had a very vigorous, very rampant decline in the percentage that charities have picked up for hospital care.

And getting back to filling out these forms, any human being, once they start filling out these forms, they are going to send it in and collect. And I think physicians, hospitals, and dentists always do that, and there is nothing much free then. But I think ordinarily, when they do not have to fill out these forms—I do not know how these physicians, when they go through the hospitals, make sure they see a patient twice in 1½ hours, whether to submit an added fee for that or not, but if they do not have to fill out the form, I suspect they do not. That would be part of the incentive.

I think from what you have said, there is some logical, basic, human nature incentive to prepayment.

Dr. DAVIS. It seems to work that way.

Senator MELCHER. Do you agree with that, Dr. Wilensky?

Dr. WILENSKY. I believe that prepayment provides incentives for physicians to provide less services and to have less hospitalizations. I think there is some indication that lowers costs.

My concern about both prepayment and the prospective payment system is that we do not know exactly what they do. We do not know how much they will lower costs, if they will lower costs at all. We have some indications from the States that have used rate-setting, that prospective payment will lower costs. We do not know, if they do lower costs, what else they do. I think it is important that we all realize that at this stage, we do not know exactly what the effects will be, and we ought to be sure we are willing to make any tradeoffs in the cost-quality relationship which may be implied. I believe that generally, if you lower costs substantially, you will affect the quantity and quality of services provided. I do not believe there is not so much inefficiency in the system that we can assume to do otherwise. Furthermore, if you succeed in squeezing down costs, there is not any, really good reason to believe that it is the inefficiency that is going to get squeezed rather than the rest of the system. I believe we really want to lower the rate of increase in health care costs, we are going to have to give something up. It may be that when we come to that decision, we will decide the tradeoff is not worthwhile. It sounds as though this is what you are suggesting may happen.

Senator MELCHER. I remember having a fractured ankle when I was about 12 years old. In this little town where I lived, I got to know—I had heard of him, but I had never known him—I got to know Dr. Reich, the community's only physician, very well. We were able to pay our bills, but an awful lot of people in the thirties never did pay their bills at any time during that decade. But Dr. Reich, while he was very conscientious about always providing his help for everybody who was ill or injured, was prudent enough to write out the bills, and when they did not pay, he was also prudent enough to save it. According to the standards of the community, he was doing all right all during the thirties. He was doing all right. One of his youngsters was a particular friend of mine, and I knew from experience that he lived higher on the hog than we did.

But the amazing part of Dr. Reich's prudence was that in the forties, when he did bill everybody, they paid, and he became a very wealthy man. There was no statute of limitations on his books. He had every item. He filled it all out, and even though it was a house call at $2, and an office call at $1, he got very wealthy, because they practically all paid. But he was willing to do that, to keep the records, and mark them down every time.

I think prepayment has some real advantages, if we can have a basic incentive to hold down costs and just within us as human nature, as individuals, hospitals, and individual physicians. But I do not want to sacrifice the service.

Chairman HEINZ. Senator Melcher, thank you very much.

One last question, and I hope we do not end on too discouraging a note, but has any industrialized country solved the problem of rapid increases in health care costs?

Dr. Davis, do you know of any that have?

Dr. DAVIS. Inflation seems to be common to all countries. Other countries for the most part have a lower fraction of the gross national product going toward health care. Canada is about 7 percent, versus about 10 percent here.

Chairman HEINZ. At what rate is it growing?

Dr. DAVIS. You have to think about the inflation in the country first, and then how fast is the health system going up relative to that, but they have held it at 7 percent for about 5 or 6 years, whereas we have been going up steadily.

Chairman HEINZ. Yes; I know they did for a while. The question is what rate is it growing at now?

Dr. DAVIS. 1980 is the last data I have seen for Canada, but it is still holding at about 7 percent.

Chairman HEINZ. I do not have explicit information on this, but my understanding is that in the last 3 or 4 years, Canada has really run into some problems. It was supposed to be the Nirvana of health care at one point. My understanding is that the bow tree has kind of fallen on whoever was sitting under it, but I need more information.

Dr. Wilensky.

Dr. WILENSKY. Yes; the rate of increase that other countries are experiencing is extremely discouraging. When you look across the industrialized countries at countries which have very different systems, including those with more government involvement and with and without cost sharing, the rates at which their health care costs have gone up have been almost uniformly high.

It has been high in Sweden. You asked about Canada. The latest figures that I have seen are for 1975 to 1977, when it was 13 percent; for France, the 1978–79 increase was almost 17 percent. West Germany recently has had a lower rate of increase although their share of GNP going to health is about the same as ours. They had a very high rate of increase in the early seventies, but a slower rate thereafter. The Scandinavian countries were having a rate of increase of 9 or 10 percent at the time that we were having a 12-percent rate of increase.

We have a high share of our GNP already in health care, close to 10 percent. Of more concern, however, is the rate of increase we have been experiencing. Furthermore, it appears to be more than just the institutional peculiarities of our system since it is so common across other industrialized countries.

Chairman HEINZ. Dr. Newhouse.

Dr. NEWHOUSE. I agree with what Dr. Wilensky said. I would also note that there is a strong relationship across countries between their income and the fraction of their GNP that they spend. Wealthier countries spend more. But with respect to the rate of increase—Dr. Davis was right. Canada's rate of increase has recently been below the others, but most countries have been going up.

Chairman HEINZ. Well, just so no one ends up getting too depressed on that note, I would suggest that this country is capable not only of independent action, but in keeping things under control in certain ways. If you view the social security systems, the income for the elderly upon retirement, this country, compared to other industrialized countries, particularly as a result of the bill that is going to the President, this country today has a remarkably sound system, compared to the others. It operates at a relatively lower level of GNP than other countries, and while there are many difficulties here in the health care area, and while it is particularly susceptible, as one might expect, being a high-tech industry, to countries that are moving more and more into the high-tech age, the correlation is not coincidental that there are more difficulties here. I do not think any of you would counsel giving up the fight to do better than our brethren in the other industrialized countries—I do not see any heads being shaken in disagreement.

I thank you all for your help today.

The hearing is adjourned.

[Whereupon, at 12:30 p.m., the committee adjourned.]

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